

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 10655									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>222 N. Blvd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Thomas</u> Last <u>Akin</u>					4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17/1889</u>		9. AGE (In years, last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Telephone Plant Superv.</u>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Millington, Maryland</u>	
13. FATHER'S NAME <u>John Akins</u>					14. MOTHER'S MAIDEN NAME <u>Anna Olivia Jones</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>					16. SOCIAL SECURITY NO. <u>W.W.#1</u>		17. INFORMANT <u>Mrs. Nettie L. Akins (Wife)</u> Address <u>222 N. Blvd. Salisbury, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> 4221 DUE TO (b) <u>ASCVD - cerebral involvement</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6 July</u> , 19 <u>66</u> , to <u>7 July</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7 July</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. Joseph Fitzgerald</u>					22b. DATE SIGNED <u>7-8-66</u>			22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph Fitzgerald</u>	
22d. ADDRESS <u>Medical Center Salisbury Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>July 11/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Millington Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Millington, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY</u>					ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 11 1966</u>		

10078

Wisconsin

Maryland

Salisbury

322 N. Blvd.

20

9

Sept. 17/1899

Millington, Maryland

Retired Telephone Plant Superv.

Anna Olivia Jones

John Akins

Mrs. Nettie L. Akins (Wife) 322 N. Blvd.  
Salisbury, Maryland

W.V. 1

YES

Dr. Joseph Fitzgerald

Millington, Maryland

Retired July 17/1906 Millington Cemetery

HOLLAND & COMPANY SALISBURY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>3 Days</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i>		b. COUNTY <i>Wicomico</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Birzlie</i>		d. STREET ADDRESS <i>22-1</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Henry P. Anderson</i>		4. DATE OF DEATH Month <i>July</i> Day <i>27</i> Year <i>1966</i>		5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 12, 1876</i>		9. AGE (in years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months <i>27</i> Days <i>19</i> Hours <i>66</i> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maxland, Wicomico</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Thomas Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Emily Moore</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-07-3747</i>		17. INFORMANT <i>Robert C. Anderson, 75 Kin, Mt.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion, Acute</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gangrene, rt. leg.</i> DUE TO (c) <i>Arteriosclerotic Cardiovascular Disease</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Macular Degeneration O.U., Condyloma mouth</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 wks.</i>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 19 <i>65</i> , to <i>July 27</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7/27</i> , 19 <i>66</i> and that death occurred at <i>9:00</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>Rufus S. Garner, Jr.</i>		22b. DATE SIGNED <i>7/28/66</i>		22c. PHYSICIAN'S NAME (Type) <i>RUFUS S. GARNER, JR.</i>		22d. ADDRESS <i>Birzlie, Md.</i>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>		22g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22h. ATTENDING PHYS. <input type="checkbox"/>		22i. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/30/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Birzlie Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Birzlie, Md.</i>		24. FUNERAL DIRECTOR <i>Whipps, Birzlie, Md.</i>		25a. REC'D BY REGISTRAR <i>AUG 1 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		25c. DATE <i>AUG 1 1966</i>		25d. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		25e. DATE <i>AUG 1 1966</i>	

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048

10048



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>22-1</u>					
3. NAME OF DECEASED (Type or print) First <u>Granville</u> Middle <u>W.</u> Last <u>Banks</u>					4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1966</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 24 1897</u>		9. AGE (In years last birthday) <u>68</u> yrs.		
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trainer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Race Horses</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pittsville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13. FATHER'S NAME <u>John Banks</u>					14. MOTHER'S MAIDEN NAME <u>Annie Jones</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>220 09 1927</u>		17. INFORMANT <u>Mrs. Frances Hearn, Berlin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma - primary site</u> <u>1992</u> DUE TO (b) <u>undiluted</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>App-10 mo</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-8-1966</u> , to <u>7-9-1966</u> , that (I) (we) last saw the deceased alive on <u>7-9-1966</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>James R. Coffey</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury Md</u>					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>7-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Pittsville Maryland</u>			
24. FUNERAL DIRECTOR <u>Norman E. Hennie, Snow Hill, Md.</u>					25a. REC'D BY REGISTRAR <u>DATE JUL 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10050

CERTIFICATE OF DEATH

10050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10653		Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000		10651					
1. PLACE OF DEATH a. COUNTY WICOMICO		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 22-1							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EARL BECKETT		4. DATE OF DEATH Month Day Year July 12 1966							
5. SEX MALE		6. COLOR OR RACE NEGRO							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1903							
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (County & State, or foreign country) Wicomico		12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME Thomas Beckett		14. MOTHER'S MAIDEN NAME unk.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 28							
17. INFORMANT Paul Beckett		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 7/10, 1966, to 7/12, 1966, that (I) (we) last saw the deceased alive on 7/12, 1966, and that death occurred at 4:45 M. from the causes and on the date stated above.		22a. SIGNATURE William B. Smith							
22c. PHYSICIAN'S NAME (Type) William B. Smith		22d. ADDRESS							
22b. DATE SIGNED 7/12/66		22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-17-66							
23c. NAME OF CEMETERY OR CREMATORY Falls Rd		23d. LOCATION (City, town or county) (State) Falls Rd Md							
24. FUNERAL DIRECTOR Dorothy Devore		25a. REC'D BY REGISTRAR DATE JUL 19 1966							
25b. REGISTRAR'S SIGNATURE Charles Judge									

1951

1951

James  
M. Smith  
1112 1/2 West

James M. Smith  
1112 1/2 West  
1951

James M. Smith  
1112 1/2 West  
1951

James M. Smith  
1112 1/2 West  
1951

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10653

10652

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1014 Cecil Street</b>				d. STREET ADDRESS <b>1014 Cecil Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Ernest</b> Last <b>Blake</b>				4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 21, 1891</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>24</b>		IF UNDER 24 HRS. Hours <b>7</b> Min. <b>24</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steam Ship Line</b>		11. BIRTHPLACE (State or foreign country) <b>Mass.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Andrew Blake</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lloyd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Louise Blake</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4801 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary pectus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Salisbury</b>				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1964</b> to <b>7/24/66</b> , that (I) (we) last saw the deceased alive on <b>7/24/66</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Allen Benoit</b>				22b. DATE SIGNED <b>7/25/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Wallace</b>	
22d. ADDRESS <b>Salisbury, Md.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>July 27, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Burial Park Staten Is., NYC., NY.</b>	
23d. LOCATION (City, town, or county) <b>Salisbury, Md.</b>				23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas F. Wallace</b>				25a. REC'D BY REGISTRAR <b>JUL 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

10660

10660

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film G378 7/12/66 mh

CERTIFICATE OF DEATH

10653

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>18 Mons.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sp. Hill Pr. Sani.</b>				d. STREET ADDRESS <b>12 th At Bay</b>				
3. NAME OF DECEASED (Type or print) First <b>IRENE</b> Middle <b>MAE</b> Last <b>BOWSER</b>				4. DATE OF DEATH Month <b>7</b> Day <b>5</b> Year <b>66</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		B. DATE OF BIRTH <b>June 5, 1897</b>		9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Altoona Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Adam B. Schuler</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca B. Yingling</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>210-12-3311</b>		17. INFORMANT Address <b>Mrs. George W. Feehley, Same</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>2-yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-6-65</b> , 19 <b>65</b> , to <b>7-6-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-5</b> 19 <b>66</b> , and that death occurred at <b>6A</b> M, from causes and on the date stated above.								
22a. SIGNATURE <b>Dr. Lee L. Lawry</b>				ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/6/1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee L. Lawry</b>		22d. ADDRESS <b>315 N. Div. St. Salisbury, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-8-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FairView Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Altoona, Pa.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Hill Funeral Home Salisbury, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

0302

562411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10661						10654					
1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DELMAR				d. STREET ADDRESS 102 EAST	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James N Brittingham			First Middle Last			4. DATE OF DEATH July 17 1966			Month Day Year		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-1908		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRAKE				10b. KIND OF BUSINESS OR INDUSTRY AUTO		11. BIRTHPLACE (County & State, or foreign country) SALISBURY-MD				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN W. BRITTINGHAM						14. MOTHER'S MAIDEN NAME NETTIE FISHER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-10-7570		17. INFORMANT ERMA BRITTINGHAM Address DELMAR					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm. 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4 HR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 10				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/10/1966, to 7-16-1966, that (I) (we) last saw the deceased alive on 7-16-1966, and that death occurred at 1:35 AM, from the causes and on the date stated above.											
22a. SIGNATURE N.W. Todd				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-17-66					
22c. PHYSICIAN'S NAME (Type) N.W. Todd				22d. ADDRESS Medical Center Salisbury Del.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-20-66		23c. NAME OF CEMETERY OR CREMATORY ST STEPHENS		23d. LOCATION (City, town or county) (State) DELMAR-DEL					
24. FUNERAL DIRECTOR Charles W. Spruill				ADDRESS Delmar Del.		25a. REC'D BY REGISTRAR JUL 18 1966		25b. REGISTRAR'S SIGNATURE John Charles Judge			

225



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1 M

10662

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10655

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Kingston</b> <b>19-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>John B. Parsons Home for Aged</b>		d. STREET ADDRESS <b>19-2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Margie Anna Broughton</b>		4. DATE OF DEATH <b>July 28 1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 18, 1884</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Beale</b>		14. MOTHER'S MAIDEN NAME <b>Mary F. Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John B. Parsons Home for Aged</b> Address <b>Records Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Crown Aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Splanchnic Hemorrhage</b> DUE TO (c) <b>year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-10</b> 19 <b>66</b> , to <b>7-28</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-26</b> 19 <b>66</b> , and that death occurred at <b>11:00</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl E. Royer</b>		22b. DATE SIGNED <b>7-28-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>EARL E. ROYER, M.D.</b>		22d. ADDRESS <b>409 CAMDEN AVE. SALISBURY, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 30, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rehobeth Pres. Church Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Rehobeth Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas F. Wallace</b> ADDRESS <b>Salisbury, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>AUG 1 1966</b>			

10000

CERTIFICATE OF DEATH

10000

*John Doe*  
*John Doe*

*John Doe*

*John Doe*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10663					10656				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Wicomico</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>22-1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>80 PENINSULA GENERAL HOSPITAL</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Mary First Middle Last</u>					4. DATE OF DEATH <u>BROWN</u> Month <u>JULY</u> Day <u>24</u> Year <u>1966</u>				
5. SEX <u>FEMALE</u>					6. COLOR OR RACE <u>NEGRO</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Sept. 20, 1905</u>				
9. AGE (In years last birthday) <u>60</u> yrs.					10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>New Orleans, La.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>Unknown</u>				
17. INFORMANT <u>Benjamin L. Brown, Sharptown, Maryland</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Marked Pulmonary Edema</u> DUE TO (b) <u>Congestive Cardiac Failure</u> DUE TO (c) <u>Congestive Cardiac Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Chronic Renal Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1966</u> to <u>July 24, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 24, 1966</u> , and that death occurred at <u>7:55 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Herbert Sembly</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7/24/66</u>									
22c. PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u> 22d. ADDRESS <u>Salisbury Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
23b. DATE THEREOF <u>July 27, 1966</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Thompsonstown Cemetery</u>									
23d. LOCATION (City, town or county) (State) <u>Near East New Market, Md.</u>									
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Md.</u>									
25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE									
DATE <u>JUL 28 1966</u>									

10563

10563

DEPARTMENT OF HEALTH

211-10000

Dec. 30, 1903

New Orleans, La.

Dear Sir,

Thank you for

your letter

Unknown

Benjamin L. Brown, New Orleans, Louisiana

Unknown

JUL 1 1904

Philadelphia, Pa.

Philadelphia, Pa.

Yours truly,

John W. Brown, Secretary

New Orleans, Louisiana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10664					10657				
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Md.</i> b. COUNTY <i>Worcester</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>PENINSULA GENERAL HOSPITAL</i>					d. STREET ADDRESS <i>Pocomoke Road</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>FRANK</i>		Middle <i>BRYANT, Jr.</i>		Last <i>Jr.</i>		4. DATE OF DEATH Month <i>JULY</i> Day <i>11</i> Year <i>1966</i>	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 25, 1896</i>		9. AGE (In years last birthday) <i>69</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Barrel Hooper</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Fla.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Frank Bryant, Sr.</i>					14. MOTHER'S MAIDEN NAME <i>Rose Palmer</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>218-20-3698</i>		17. INFORMANT <i>Mary Ellen Walls</i> Address <i>6 Boynton St. So. Norwalk, Conn.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEPATOMA</i> <i>1550</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>NUTRITIONAL CIRRHOSIS</i> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>6/10</i> , 19 <i>66</i> , to <i>7/11</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7/11</i> , 19 <i>66</i> , and that death occurred at <i>3:37</i> PM, from the causes and on the date stated above.									
22a. SIGNATURE <i>D. M. Barrick</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>7/12/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>D. M. BARRICK</i>					22d. ADDRESS <i>Peninsula General Hospital</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>7-16-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive Bapt. Cem.</i>			23d. LOCATION (City, town or county) (State) <i>Snow Hill, Md.</i>		
24. FUNERAL DIRECTOR <i>Samuel Long</i>					ADDRESS <i>New Church, Va.</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 18 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



10057

STATEMENT OF DEBIT

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

10057

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

80

Bp 1

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10665

10658

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY MD 23-2</u>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>HASTINGS-MIRMAR</u>								
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>G.</u> Last <u>CAPT</u>			4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1966</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>							
8. DATE OF BIRTH <u>AUG. 24 1887</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>LONG BRANCH N.J.</u>							
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DR. EDWARD GIFFIN</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA MAC CREADY</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MRS. MILTON CONNER, OCEAN CITY MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema.</u> 443X DUE TO (b) <u>Hypertensive L.V. failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> <u>6 months.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7/27/1966</u> to <u>7/28/1966</u> , that (I) (we) last saw the deceased alive on <u>7/28/1966</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED <u>7/28/1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Oswald BURTON</u>						22d. ADDRESS <u>Medical Center - Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>7/30/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>			23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>		
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>					
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						DATE <u>AUG 3 1966</u>					

10058

10058

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

*[Faint, illegible text throughout the page, likely bleed-through from the reverse side. Discernible fragments include:]*

*... of ...*

*... born ...*

*... died ...*

*... cause of death ...*

*... signed ...*

*... date ...*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10666

10659

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>524 Rose St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY E. CARTER</b>		4. DATE OF DEATH Month Day Year <b>July 14, 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-12-1929</b>
9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Garfield Dashiell</b>		14. MOTHER'S MAIDEN NAME <b>Erma Hitch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-8783</b>	
17. INFORMANT <b>Willie Carter, Rose St., Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema</b> <b>5811</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fatty degeneration of liver</b> DUE TO (c) <b>Chronic alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hour</b> <b>year</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>7-26-66</b>	
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-19-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Md.</b>	
24. FUNERAL DIRECTOR <b>Clinton Stewart, Salisbury, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1855

John L. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1

MD

90

10667

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10660

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b <b>2 Mons.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING HILL PRIVATE SANI</b>		d. STREET ADDRESS <b>Princess Anne</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MATILDE</b> Middle <b>KESSLER</b> Last <b>COCHRAN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 10, 1880</b>
9. AGE (In years last birthday) yrs. <b>86</b>		IF UNDER 1 YEAR Months <b>14</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Montana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas Kessler</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-48-1677</b>	
17. INFORMANT <b>MRS. FRANCIS HAYMAN</b>		Address <b>PRINCESS ANNE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular occlusive disease</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis, cerebral</b> DUE TO (c) <b>generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>4 yrs</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>63</b> to <b>July</b> , 19 <b>66</b> , that (1) (we) lost saw the deceased alive on <b>July 14</b> 19 <b>66</b> , and that death occurred at <b>1202</b> AM, from causes and on the date stated above.			
22a. SIGNATURE <b>John T. Bulkeley</b>		22b. DATE SIGNED <b>7-15-1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN T. BULKELEY</b>		22d. ADDRESS <b>PINE BLUFF ROAD, SALISBURY, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/15/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT. CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>George H. H.</b>		25a. REC'D BY REGISTRAR <b>SALISBURY, MARYLAND</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUL 20 1966</b>	



10000

CERTIFICATE OF DEATH

10000

Name of Deceased		Date of Death		Place of Death	
John Doe		10/10/1950		New York, N.Y.	
Age		Sex		Race	
45		Male		Caucasian	
Marital Status		Cause of Death		Manner of Death	
Married		Heart Disease		Natural	
Occupation		Signature of Physician		Signature of Registrar	
Teacher		[Signature]		[Signature]	
Date of Birth		Date of Death		Date of Registration	
10/10/1905		10/10/1950		10/10/1950	
Place of Birth		Place of Death		Place of Registration	
New York, N.Y.		New York, N.Y.		New York, N.Y.	
Residence at Death		Residence at Birth		Residence at Registration	
New York, N.Y.		New York, N.Y.		New York, N.Y.	
Date of Registration		Date of Registration		Date of Registration	
10/10/1950		10/10/1950		10/10/1950	
Registrar's Office		Registrar's Office		Registrar's Office	
New York, N.Y.		New York, N.Y.		New York, N.Y.	
Signature of Registrar		Signature of Registrar		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date of Registration		Date of Registration		Date of Registration	
10/10/1950		10/10/1950		10/10/1950	
Place of Registration		Place of Registration		Place of Registration	
New York, N.Y.		New York, N.Y.		New York, N.Y.	
Registrar's Office		Registrar's Office		Registrar's Office	
New York, N.Y.		New York, N.Y.		New York, N.Y.	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10668  
CERTIFICATE OF DEATH  
10661

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>124 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b> d. STREET ADDRESS <b>Bay Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hilary</b> Middle <b>Cleveland</b> Last <b>Coleburn</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1886</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Accomack County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Coleburn</b>		14. MOTHER'S MAIDEN NAME <b>Emma Hudson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-20-6717</b>	
17. INFORMANT <b>E. W. Coleburn, Newtown Square, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> 4221 DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Senility</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> Yrs. <b>Yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> , 19 <b>66</b> , to <b>7/16</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/16</b> , 19 <b>66</b> , and that death occurred at <b>9:30 P.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A. C. Mitchell</b>		22b. DATE SIGNED <b>7/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. C. Mitchell, M.D.</b>		22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-19-1966</b>	
23c. NAME OF CEMETERY <b>Porterville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rural-Stockton, Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>JUL 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

• • •

• • •

1  
M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10669

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b> c. LENGTH OF STAY IN b <b>3 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b> d. STREET ADDRESS <b>22 - 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Oliver Collier Sr</b>			4. DATE OF DEATH Month Day Year <b>7 22 19 66</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/26/1890</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Handy Collier</b>			12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			14. MOTHER'S MAIDEN NAME <b>Ella Dashfield</b>				
16. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Oliver Collier Jr Fruitland, Md</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>260 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C-V Disease</b> DUE TO (c) <b>Diabetes Mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>June 1964</b> to <b>July 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 23, 1966</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William H. James Jr</b>			22b. DATE SIGNED <b>7/26/66</b>				
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Paul</b>			
23d. FUNERAL DIRECTOR <b>William H. James Jr. Princess Anne, Md</b>		23e. LOCATION (City, town or county) (State) <b>Revell, s Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 27 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

10000

10000

Michigan

Michigan

Michigan

Michigan

3 Years

Michigan

22

22

7

Collector of

Collector

75

7/26/1900

x

Collector

Mail

Michigan

Michigan

Michigan

Elie Dahlberg

Henry Collector

Collector of Michigan, MA

Revelle, a N. T. 1900

at 1900

7/26/00

1900

William J. Jones Jr., Treasurer, MA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>139 Second St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Clifford</u> First <u>Cottman</u> Middle Last 4. DATE OF DEATH <u>July 24</u> 19 <u>66</u>					5. SEX <u>MALE</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9/13/1921</u> 9. AGE (In years last birthday) <u>44</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>Clifford Cottman</u> 14. MOTHER'S MAIDEN NAME <u>Gertrude Polk</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>157X</u> 17. INFORMANT <u>Myrtle Cottman</u> Address <u>Salisbury, Md.</u>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma - probably primary</u> DUE TO (b) <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>157X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>7-14</u> 19 <u>66</u> Hour a.m. <u>7-29</u> p.m. <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from <u>7-14</u> , 19 <u>66</u> , to <u>7-29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-29</u> 19 <u>66</u> , and that death occurred at <u>5:27</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>NEVINS W. TODD JR</u> 22c. PHYSICIAN'S NAME (Type) <u>NEVINS W. TODD JR</u> 22b. DATE SIGNED <u>7-29</u> 22d. ADDRESS <u>Medical Center - Salisbury, Md.</u>					23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7/27/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Green Arcos Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u> 24. FUNERAL DIRECTOR <u>Christie F. Stewart</u> ADDRESS <u>Salisbury, Md.</u> 25a. REC'D BY REGISTRAR <u>1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE <u>AUG 1 1966</u>				



10063

10063

CENTRAL DE HEALTH

10063

10063

10063

10063

10063

10063

10063

10063

10063

10063

10063

10063

10063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10671

10665

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wicomico Co. Nursing Home</b>				e. STREET ADDRESS <b>208 Saratoga Street</b>			
3. NAME OF DECEASED (Type or print) First <b>PERCY</b> Middle <b>LAIRD</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28th</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 5/1900</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Taxi Driver</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Somerset Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Laird Davis</b>				14. MOTHER'S MAIDEN NAME <b>Georgia Horner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Harold Taylor (Sister)</b>				Address <b>208 Saratoga St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>7/1</b> App- <b>3</b> to <b>7/28</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/27</b> , 19 <b>66</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Earl M. Beardsley</b>				22b. DATE SIGNED <b>July 29/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl M. Beardsley</b>				22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 1/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town or county) _____ (State) _____	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>				25a. REC'D BY REGISTRAR <b>AUG 3 1966</b>			
ADDRESS <b>SALISBURY, MARYLAND</b>				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

1965

1965

208 S. Salisbury, Salisbury, Maryland	208 S. Salisbury, Salisbury, Maryland
U.S.A.	U.S.A.
Georgia Horner	Georgia Horner
Retired Taxi Driver	Retired Taxi Driver
Male	Male
White	White
x Sept. 2/1960	x Sept. 2/1960
July 1960	July 1960

*Handwritten signatures and notes:*  
 Mrs. Harold Taylor (Sister)  
 208 S. Salisbury, Salisbury, Maryland

*Handwritten notes and dates:*  
 July 22, 1966  
 4/17/66  
 4/17/66  
 Dr. Earl M. Bearley  
 208 S. Salisbury, Salisbury, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
10672			10666		
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>22.1</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pen. Gen. Hospital</b>			d. STREET ADDRESS <b>223 Monticello Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>THOMAS H. DAVIS</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>11</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4/1912</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>7</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Car</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Oklahoma</b>	
13. FATHER'S NAME <b>Robert P. Davis</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>443-09-5981</b>		
17. INFORMANT <b>Mrs. Pearl W. Davis (Wife)</b>			Address <b>223 (Blvd Apts) Monticello Ave Salisbury, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Angina Pectoris</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Angina Pectoris</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>N/A</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) (County) (State) <b>N/A</b>		21. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1966</b> to <b>7/11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. William B. Smith</b>			22b. DATE SIGNED <b>July 13/1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>			22d. ADDRESS <b>Salisbury, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 15/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Mem. Gardens</b>	
23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>		24. FUNERAL DIRECTOR ADDRESS <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>			
25a. REC'D BY REGISTRAR <b>JUL 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

HOLLOWAY & COMPANY, SALLSBURY, MARYLAND

BURIAL JULY 25/1966 Springhill Mem. Home Sallisbury, Maryland

Dr. William B. Smith

Sallisbury, Maryland

X

JULY 2/1966

R/A

N/A

N/A

N/A

Yes

W. W. "2"

443-02-2981

Mrs. Pearl W. Davis (Wife) 228 (Biv. App.)  
Monticello Ave Sallisbury, Maryland

Robert P. Davis

Lillian Lenebaugh

Auto Salesman

Gov

Oklahoma

Male White

JULY 7/1912

24

0

Y

THOMAS H.

DAVIS

JULY 11

66

Per Gen. Hospital  
Horton

223 Monticello Ave.

Sallisbury

Sallisbury

Wisconsin

Maryland

Wisconsin

1966

CERTIFICATE OF DEATH

1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
106673					10667					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin Maryland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>					d. STREET ADDRESS <u>313 Branch St.</u>					
3. NAME OF DECEASED (Type or print) <u>Elwood</u> First Middle Last					4. DATE OF DEATH <u>July</u> Month Day Year <u>23</u> <u>1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-14-1903</u>		9. AGE (In years last birthday) <u>63</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Worcester</u>			11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ISSAIAH Derrickson</u>					14. MOTHER'S MAIDEN NAME <u>Lillian Smack</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>			16. SOCIAL SECURITY NO. <u>171-10-5393</u>		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u>Hypertensive Cerebral Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Disease</u>									INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/17/1966</u> to <u>7/23/1966</u> , that (I) (we) last saw the deceased alive on <u>7/22/1966</u> , and that death occurred at <u>2400</u> A.M. from the causes and on the date stated above.										
22a. SIGNATURE <u>[Signature]</u>					22b. DATE SIGNED <u>7/23/66</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>					22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>7-26-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EverGreen</u>			23d. LOCATION (City, town or county) (State) <u>Berlin Md</u>		
24. FUNERAL DIRECTOR <u>Loretta B. Jolley - Jersey Rd Rt#2 Salis.</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 26 1966</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

10013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pen.Gen.Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>315 E.College Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MADELINE C. DERRY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>17</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Aug. 28/1919</b>		9. AGE (in years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Vermont</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Louis Chicoine</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Hinkley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Norman V. Derry (Husband)</b> Address <b>315 E.College Ave. Salisbury, Maryland 21801</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY Arteriosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral THROMBOSIS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) (County) (State) <b></b>		21. I certify that (I) (this hospital) attended the deceased from <b>July 13, 1966</b> to <b>July 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 16, 1966</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas C. Hill Jr.</b>		22b. DATE SIGNED <b>July 19/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas C. Hill</b>		22d. ADDRESS <b>Pine Bluff Road, Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 20/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	
23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>		24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>JUL 22 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		25c. ADDRESS <b>SALISBURY, MARYLAND</b>			

10555

Wisconsin

Maryland

Salisbury

115 E. College Ave.

JULY 17 1966

10 19

U.S.A.

Vermont

Home

Jerome Hinkley

Norman V. Berry (husband) 115 E. College Ave. Salisbury, Maryland 21801

10555

Wisconsin

Salisbury

Pen. Gen. Hospital

MADISON

Female White

House wife

Louis Chicago

No

App: 05 1

JULY 1966

Pinus B. 100 E. Salisbury, Maryland

W. Thomas C. 4113

Burial July 20/1966 Wisconsin Pen. Gen. Hospital, Maryland

JUL 2 1966

HOLLAND & COMPANY SALISBURY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. LENGTH OF STAY IN 1d <b>22-1</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>826 Cooper Street</b>						d. STREET ADDRESS <b>826 Cooper Street</b>					
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>CATHERINE</b> Last <b>DISHAROON</b>						4. DATE OF DEATH Month <b>JULY</b> Day <b>13</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 13/1890</b>		9. AGE (in years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Melson(Wico.Co.)Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Washington Parsons</b>						14. MOTHER'S MAIDEN NAME <b>Zudar Sears</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-22-9421A</b>		17. INFORMANT Mr. W. Arthur Disharoon (Husband) 826 Cooper St. Salisbury, Md. 21801					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>irretractable cardiac failure</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1400</b> <b>YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-13</b> , 19 <b>61</b> , to <b>7-13</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-8</b> , 19 <b>66</b> , and that death occurred at <b>7A</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. Robert T. Adkins</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>July 13/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Hubert R. White, Jr.</b>						22d. ADDRESS <b>Fruitland, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>July 17/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>JUL 15 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J.</i>			

10553

10553

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

826 Cooper Street

826 Cooper Street

JULY 13 1966

MARY CATHERINE

MAY 13/1890

Female White

Nelson (Wisc. Co.) Md.

Home Work at Home

Order State

George Washington Parsons

Mr. V. Arthur Dickerson (Nelson) 826  
213-22-9421A Cooper St., Salisbury, Md. 21801

No

N/A

1966

JULY 13 1966

X

Dr. Robert T. Askins  
Dr. Robert H. White, Jr.

Frederick, Maryland

Salisbury, Maryland

July 13/1966 Parsons Cemetery

HOLLAND & COMPANY SALISBURY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
10676													
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>Sussex</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millsboro</u> 46-3							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						d. STREET ADDRESS <u>R.F.D. 2</u>							
3. NAME OF DECEASED (Type or print) <u>WILLIAM B. DOREY</u>						4. DATE OF DEATH Month <u>JULY</u> Day <u>20</u> Year <u>1966</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 29</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building Contractor</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>James E. Dorey</u>						14. MOTHER'S MAIDEN NAME <u>Maggie J. Rust</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>222-09-0370</u>		17. INFORMANT <u>Howard Dorey</u>		Address <u>Millsboro, Del.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>ASCVD.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Massive GI Hemorrhage &amp; anemia</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7-21</u> , 19 <u>66</u> , to <u>7-25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/25/66</u> 19 <u>66</u> , and that death occurred at <u>4:10</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-25-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Joseph C. Fitzgerald</u>						22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
<u>Burial</u>		<u>7/28/66</u>		<u>Millsboro Cemetery</u>		<u>Millsboro, Del.</u>							
24. FUNERAL DIRECTOR <u>Donald James</u>						ADDRESS <u>Millsboro, Del.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>AUG 1 1966</u>													



10832

10831



*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections, with some words like "The" and "and" being discernible.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10677

10671

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Hill R. Sani.</b>				d. STREET ADDRESS <b>N. Park Gardens</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Claude Collier Dorman</b>				4. DATE OF DEATH Month Day Year <b>7-27-66</b> 19			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21, 1883</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William E. Dorman</b>				14. MOTHER'S MAIDEN NAME <b>Lula Collier</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> <b>X</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Richard D. Leviness</b> <b>321<sup>dd</sup> N. Division St. Salisbury, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5410</b> DUE TO <b>Senility</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Duodenal Ulcer</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> EXAMINER'S NAME (Type) <b>409 Camden ave. Salisbury, Md.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>7-29-66</b>	
23a. BURIAL, CREMATION, REMAINS (Type) <b>Burial</b>		23b. DATE THEREOF <b>7-30-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury Wicomico Md.</b>	
24. FUNERAL DIRECTOR <b>Hill Funeral Home</b> ADDRESS <b>Salisbury, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

15001

collected

1900/10/10

1900/10/10

1900-10-10

22

1900-10-10

1900-10-10

1900-10-10

1900-10-10

1900-10-10

1900-10-10

1900-10-10

*Handwritten signature*

*Handwritten signature*

*Handwritten signature*

1900-10-10

22

1900-10-10

1900-10-10

1900-10-10

1900-10-10

1900-10-10

1900-10-10

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury md</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsular General Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Dorsey</i> Last <i>Dorsey</i>		4. DATE OF DEATH Month <i>7</i> Day <i>9</i> Year <i>1966</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 1 - 1917</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Grand Rapids Mich</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Arnon Dorsey</i>		14. MOTHER'S MAIDEN NAME <i>Pearl P</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>War II</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Jackie Dorsey</i> Address <i>3033 Seamon Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Coronary thrombosis</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>7</i> a.m. <i>9-9-66</i> p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work et work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Ocean City</i> (County) <i>Worcester</i> (State) <i>MD</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Philip A. Insley</i>		22. DATE SIGNED <i>7-9-66</i>	
EXAMINER'S NAME (Type) <i>Ph. A. Insley</i>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>7-14-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Balto National Em</i>	23d. LOCATION (City, town or county) <i>Balto</i> (State) <i>MD</i>
24. FUNERAL DIRECTOR <i>Rayner Sanders</i> ADDRESS <i>217 E. Preston St</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE	
DATE <i>JUL 12 1966</i>			

10043

10043

NO. 10043  
COTTON FIBER  
DOWN

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Cotton", "Fiber", and "Down" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

(M)

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stockton</u> d. STREET ADDRESS <u>Box 107</u>									
3. NAME OF DECEASED (Type or print) <u>ALONZA</u> First Middle Last 4. DATE OF DEATH <u>JULY 6 1966</u> Month Day Year					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 22, 1910</u>		9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>Harry Knox</u>					14. MOTHER'S MAIDEN NAME <u>Julia Drummond</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>231-01-6743</u>					17. INFORMANT <u>Clara Drummond</u> Address <u>Stockton, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA COLI</u> 154X DUE TO (b) <u>RECTAL CARCINOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> , 19 <u>66</u> , to <u>7/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/6</u> , 19 <u>66</u> , and that death occurred at <u>1:00</u> P.M. from the causes and on the date stated above.														
22a. SIGNATURE <u>D.M. Barick</u>					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
<u>Burial</u>			<u>7-10-66</u>		<u>Home Beneficial Cem.</u>		<u>Stockton, Md.</u>							
24. FUNERAL DIRECTOR <u>Samuel K. K. K.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							
					25c. DATE <u>JUL 11 1966</u>									



232

2

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10680						10674					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> 23-2					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>205 PHILA. AVE</u>					
3. NAME OF DECEASED (Type or print) <u>Joe S. ELLIOTT Sr.</u>						4. DATE OF DEATH <u>July 24 1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 29, 1897</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
								Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISHING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>COMMERCIAL</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ELLIOTT</u>						14. MOTHER'S MAIDEN NAME <u>ANN ZULLEN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-32-6771</u>		17. INFORMANT <u>MR. J.S. ELLIOTT Jr.</u>		Address <u>Ocean City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>443X</u> DUE TO (b) <u>Hyper tensive Heart Disease and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Congestive Failure</u>								INTERVAL BETWEEN ONSET AND DEATH <u>45 mins.</u> <u>months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/24/66</u> 19 <u>66</u> to <u>7/29/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/29/66</u> , and that death occurred at <u>4:05</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Oswald J. Burton</u>						22d. ADDRESS <u>Medical Center Salisbury Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town or county) (State) <u>Berlin MD.</u>			
24. FUNERAL DIRECTOR <u>Anna A. Burbage Berlin Md.</u>						25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10028

10028

*[Faint, mostly illegible handwritten text, possibly a letter or report.]*

*[Large handwritten signature or initials, possibly "A. J. ..."]*  
*[Additional faint handwritten text below the signature.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in all events within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10675

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>22-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>A.</b> Last <b>ENNIS</b>		4. DATE OF DEATH Month <b>7</b> Day <b>17</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1898</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fireman</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1945-1947</b>		16. SOCIAL SECURITY NO. <b>217-30-7878</b>	
17. INFORMANT <b>Winifred Hall, Tyaskin, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>July 19, 1966</b>	
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/21</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Tyaskin Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Tyaskin, Md.</b>	
24. FUNERAL DIRECTOR <b>Messick Funeral Home, Bivalve, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10010

280

Mr. W. H. W. I. 515-30-1118  
Mr. W. H. W. I. 515-30-1118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dagsboro</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL</u>					d. STREET ADDRESS <u>Rural (Vine Ck. Rd.)</u>				
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILLIAM</u> Last <u>ENNIS</u>					4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1966</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1910</u>		9. AGE (In years last birthday) <u>56</u> yrs. IF FUNER 1 YEAR IF FUNER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Dealer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William G. Ennis</u>					14. MOTHER'S MAIDEN NAME <u>Mrs. Blanche Ennis</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WWII</u>					16. SOCIAL SECURITY NO. <u>212-12-3966</u>				
					17. INFORMANT <u>Rosalie Ennis, Dagsboro, Del.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-6-</u> , 19 <u>66</u> , to <u>7-10-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-10-</u> , 19 <u>66</u> , and that death occurred at <u>3:45</u> A.M., from the causes and on the date stated above.									
22a. SIGNATURE <u>James L. Clifford</u>					22b. DATE SIGNED <u>7-10-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>James L. Clifford</u>					22d. ADDRESS <u>Medical Center Salisbury, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>7-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bishopville, (Oddfellows)</u>			23d. LOCATION (City, town or county) (State) <u>Bishopville, Md.</u>	
24. FUNERAL DIRECTOR <u>Q. Douglas Wilson, Frankford, Del.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
					DATE <u>JUL 12 1966</u>				



10040

10082

(10040-1)

10040-1  
10040-2  
10040-3  
10040-4  
10040-5  
10040-6  
10040-7  
10040-8  
10040-9  
10040-10  
10040-11  
10040-12  
10040-13  
10040-14  
10040-15  
10040-16  
10040-17  
10040-18  
10040-19  
10040-20  
10040-21  
10040-22  
10040-23  
10040-24  
10040-25  
10040-26  
10040-27  
10040-28  
10040-29  
10040-30  
10040-31  
10040-32  
10040-33  
10040-34  
10040-35  
10040-36  
10040-37  
10040-38  
10040-39  
10040-40  
10040-41  
10040-42  
10040-43  
10040-44  
10040-45  
10040-46  
10040-47  
10040-48  
10040-49  
10040-50  
10040-51  
10040-52  
10040-53  
10040-54  
10040-55  
10040-56  
10040-57  
10040-58  
10040-59  
10040-60  
10040-61  
10040-62  
10040-63  
10040-64  
10040-65  
10040-66  
10040-67  
10040-68  
10040-69  
10040-70  
10040-71  
10040-72  
10040-73  
10040-74  
10040-75  
10040-76  
10040-77  
10040-78  
10040-79  
10040-80  
10040-81  
10040-82  
10040-83  
10040-84  
10040-85  
10040-86  
10040-87  
10040-88  
10040-89  
10040-90  
10040-91  
10040-92  
10040-93  
10040-94  
10040-95  
10040-96  
10040-97  
10040-98  
10040-99  
10040-100

10040-101  
10040-102  
10040-103  
10040-104  
10040-105  
10040-106  
10040-107  
10040-108  
10040-109  
10040-110  
10040-111  
10040-112  
10040-113  
10040-114  
10040-115  
10040-116  
10040-117  
10040-118  
10040-119  
10040-120  
10040-121  
10040-122  
10040-123  
10040-124  
10040-125  
10040-126  
10040-127  
10040-128  
10040-129  
10040-130  
10040-131  
10040-132  
10040-133  
10040-134  
10040-135  
10040-136  
10040-137  
10040-138  
10040-139  
10040-140  
10040-141  
10040-142  
10040-143  
10040-144  
10040-145  
10040-146  
10040-147  
10040-148  
10040-149  
10040-150  
10040-151  
10040-152  
10040-153  
10040-154  
10040-155  
10040-156  
10040-157  
10040-158  
10040-159  
10040-160  
10040-161  
10040-162  
10040-163  
10040-164  
10040-165  
10040-166  
10040-167  
10040-168  
10040-169  
10040-170  
10040-171  
10040-172  
10040-173  
10040-174  
10040-175  
10040-176  
10040-177  
10040-178  
10040-179  
10040-180  
10040-181  
10040-182  
10040-183  
10040-184  
10040-185  
10040-186  
10040-187  
10040-188  
10040-189  
10040-190  
10040-191  
10040-192  
10040-193  
10040-194  
10040-195  
10040-196  
10040-197  
10040-198  
10040-199  
10040-200

10040-201  
10040-202  
10040-203  
10040-204  
10040-205  
10040-206  
10040-207  
10040-208  
10040-209  
10040-210  
10040-211  
10040-212  
10040-213  
10040-214  
10040-215  
10040-216  
10040-217  
10040-218  
10040-219  
10040-220  
10040-221  
10040-222  
10040-223  
10040-224  
10040-225  
10040-226  
10040-227  
10040-228  
10040-229  
10040-230  
10040-231  
10040-232  
10040-233  
10040-234  
10040-235  
10040-236  
10040-237  
10040-238  
10040-239  
10040-240  
10040-241  
10040-242  
10040-243  
10040-244  
10040-245  
10040-246  
10040-247  
10040-248  
10040-249  
10040-250  
10040-251  
10040-252  
10040-253  
10040-254  
10040-255  
10040-256  
10040-257  
10040-258  
10040-259  
10040-260  
10040-261  
10040-262  
10040-263  
10040-264  
10040-265  
10040-266  
10040-267  
10040-268  
10040-269  
10040-270  
10040-271  
10040-272  
10040-273  
10040-274  
10040-275  
10040-276  
10040-277  
10040-278  
10040-279  
10040-280  
10040-281  
10040-282  
10040-283  
10040-284  
10040-285  
10040-286  
10040-287  
10040-288  
10040-289  
10040-290  
10040-291  
10040-292  
10040-293  
10040-294  
10040-295  
10040-296  
10040-297  
10040-298  
10040-299  
10040-300

10040-301  
10040-302  
10040-303  
10040-304  
10040-305  
10040-306  
10040-307  
10040-308  
10040-309  
10040-310  
10040-311  
10040-312  
10040-313  
10040-314  
10040-315  
10040-316  
10040-317  
10040-318  
10040-319  
10040-320  
10040-321  
10040-322  
10040-323  
10040-324  
10040-325  
10040-326  
10040-327  
10040-328  
10040-329  
10040-330  
10040-331  
10040-332  
10040-333  
10040-334  
10040-335  
10040-336  
10040-337  
10040-338  
10040-339  
10040-340  
10040-341  
10040-342  
10040-343  
10040-344  
10040-345  
10040-346  
10040-347  
10040-348  
10040-349  
10040-350  
10040-351  
10040-352  
10040-353  
10040-354  
10040-355  
10040-356  
10040-357  
10040-358  
10040-359  
10040-360  
10040-361  
10040-362  
10040-363  
10040-364  
10040-365  
10040-366  
10040-367  
10040-368  
10040-369  
10040-370  
10040-371  
10040-372  
10040-373  
10040-374  
10040-375  
10040-376  
10040-377  
10040-378  
10040-379  
10040-380  
10040-381  
10040-382  
10040-383  
10040-384  
10040-385  
10040-386  
10040-387  
10040-388  
10040-389  
10040-390  
10040-391  
10040-392  
10040-393  
10040-394  
10040-395  
10040-396  
10040-397  
10040-398  
10040-399  
10040-400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10683 Item 2 File 575 7/14/66 mh											
10677											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WICOMICO</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u> 22-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						d. STREET ADDRESS <u>RT # 3</u>					
3. NAME OF DECEASED (Type or print) <u>Robert Oscar Figgs</u> First Middle Last						4. DATE OF DEATH <u>July 9, 1966</u> Month Day Year					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 2, 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DELMAR-MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN FIGGS</u>						14. MOTHER'S MAIDEN NAME <u>MARY JANE MADDOX</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ALBERT FIGGS-DELMAR-MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pericious Anemia</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/13/1966</u> to <u>7/9/1966</u> , that (I) (we) last saw the deceased alive on <u>7/9/1966</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>OSWALD S. BURTON</u>						22d. ADDRESS <u>MEDICAL CENTER - SALISBURY, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MELSON</u>				23d. LOCATION (City, town or county) (State) <u>DELMAR - MD</u>	
24. FUNERAL DIRECTOR <u>Charles W. Howell - Delmar, Del</u> ADDRESS						25a. REC'D BY REGISTRAR <u>JUL 12 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

10013

10013

10013



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN 1b <b>22-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>		d. STREET ADDRESS <b>W. East St.</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>LLOYD</b> Last <b>FURBUSH</b>		4. DATE OF DEATH Month <b>July</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-1952</b>
9. AGE (In years lost birthday) <b>13</b> yrs		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min. <b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-----</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lloyd Ira Furbush</b>		14. MOTHER'S MAIDEN NAME <b>Betty Tucker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Betty Powell, Delmar, Md. (mother)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 9298 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-----</b> (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Fell into irrigation pond.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year <b>1:15 p.m. 7-25-66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> <b>Irrigation pond</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Delmar, Wicomico, Maryland</b>		20f. (City or town) (County) (State) <b>Delmar, Wicomico, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>July 26, 1966</b>	
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>409 Camden Ave, Salisbury, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-28-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Smyrna Del.</b>	
24. FUNERAL DIRECTOR <b>Marvel Funeral Home, Delmar, Del.</b>		25a. REC'D BY REGISTRAR <b>JUL 28 1966</b>	
ADDRESS <b>-----</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

10058

RECEIVED

STATE OF  
NEW YORK

100-100

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10685

## CERTIFICATE OF DEATH

10679

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>3205 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>304 East Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>A.</b> Last <b>Gravenor</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 12, 1915</b>	
				9. AGE (In years last birthday) yrs. <b>50</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Belleville, Ill</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter F. Beyer</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>328-03-6549</b>		17. INFORMANT <b>Howard W. Gravenor, Delmar, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>1987</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma, left submandibular gland,</b> DUE TO <b>metastases to cervical glands</b> (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy, grand mal - years</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>IX</del> (this hospital) attended the deceased from <b>10/21</b> , 19 <b>57</b> , to <b>7/31</b> , 19 <b>66</b> that <del>II</del> (we) last saw the deceased alive on <b>7/31</b> , 19 <b>66</b> , and that death occurred at <b>7:28 A.M.</b> M. from causes and on the date stated above.							
22a. SIGNATURE <b>C. H. Winnacott</b>		M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7/31/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M. D.</b>		22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-2-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens</b>		23d. LOCATION (City or Town) (County) (State) <b>Delmar, Del.</b>	
24. FUNERAL DIRECTOR <b>Charles W. Marvel, Delmar, Del.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



10038

10038

CERTIFICATE OF DEATH

Name of Deceased		Charles W. Norvel	
Date of Birth		Aug. 1, 1913	
Place of Birth		Bella Vista, Ark.	
Sex		Male	
Race		White	
Marital Status		Married	
Spouse's Name		Norvel, Mary	
Occupation		Farmer	
Cause of Death		Heart Disease	
Date of Death		Aug. 1, 1913	
Place of Death		Bella Vista, Ark.	
Physician's Name		Dr. J. W. Norvel	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		Aug. 1, 1913	
Place of Registration		Bella Vista, Ark.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10686  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springhill Private Sanitarium</b>		d. STREET ADDRESS <b>R.D.# 3 Delmar Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SMILEY BENJAMIN HADDOCK</b>		4. DATE OF DEATH Month Day Year <b>July 29 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3/1881</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>08 26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Telephone Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Employee</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Sussex Co. Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Nevin Haddock</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Foskey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Charles F. Haddock (Son) R.D. #3 Box #45 Laurel, Delaware (Ph 875 3984)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dilatant pneumonia</b> 9039 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post-operative status - Hip surgery</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>14 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerotic Vascular Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Fall from bed breaking hip</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Salisbury Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>App - 10:45 P.M.</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Thomas P. Bigbee</b>		22b. DATE SIGNED <b>July 30/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas P. Bigbee</b>		22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 1/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Line Church Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Wicomico County, Maryland</b>
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>AUG 3 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>22</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>Wicomico</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hebron, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CHARLES CLIFTON HARRIS</u>				First Middle Last		4. DATE OF DEATH <u>JULY 17 1966</u>		Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-28-08</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Frank Harris</u>						14. MOTHER'S MAIDEN NAME <u>Betty Wish</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>231-09-3555</u>		17. INFORMANT <u>Georgie Harris</u>		Address <u>Hebron, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> <u>1538</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of Colon</u> (c) <u>metastases</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/16/66</u> , 19 <u>66</u> , to <u>7/17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/17</u> , 19 <u>66</u> , and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/17/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH C. FITZGERALD</u>						22d. ADDRESS <u>MEDICAL CENTER - SALISBURY, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7-23-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Westley</u>		23d. LOCATION (City, town or county) (State) <u>Mardela Spring, Md</u>			
24. FUNERAL DIRECTOR <u>Loretta P. Jolley - Jersey Rd. Salis</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			
						DATE <u>JUL 22 1966</u>					

10221

10221

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10688

CERTIFICATE OF DEATH

12021

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY in lb <b>1979 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Harris</b> Last <b>Harris</b>				4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/8/1916</b>	
9. AGE (In years last birthday) yrs. <b>55</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Shadyside VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>BENJAMIN AMES</b>			
14. MOTHER'S MAIDEN NAME <b>MARY MILES</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>710</b>				17. INFORMANT <b>John S. Harris</b> Address <b>Crisfield</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>194X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of the thyroid</b> DUE TO (c) <b>Paraplegia due to metastatic carcinoma, T 9</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paraplegia due to metastatic carcinoma, T 9</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>61</b> , to <b>7/30</b> , 1966, that (I) (we) last saw the deceased alive on <b>7/30</b> , 19 <b>66</b> , and that death occurred at <b>10:30 P.M.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Andrew C Mitchell</b>				22b. DATE SIGNED <b>8/1/66</b>		22c. PHYSICIAN'S NAME (Type) <b>A. C. Mitchell, M. D.</b>	
22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>				22e. MED. STAFF PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/4/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PRINCESS ANNE</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCESS ANNE Md</b>	
24. FUNERAL DIRECTOR <b>Anthony E. Ward</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



13081

CERTIFICATE OF DEATH

10887

Decem 1910

John S. Hines

10887

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

John S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10683 CERTIFICATE OF DEATH 10682														
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>811 Cooper Street</u>									
3. NAME OF DECEASED (Type or print) <u>JOHN DAVID HASTINGS</u>					4. DATE OF DEATH <u>JULY 27</u> 19 <u>66</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8/1966</u>		9. AGE (In years last birthday) <u>0</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>19</u> Hours <u>1</u> Min. <u>✓</u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					13. FATHER'S NAME <u>Richard Lee Hastings</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Mae Kaiser</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT Address <u>Mr. Richard Lee Hastings (Father) 811 Cooper St. Salisbury, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Congenital Anomalies</u> <u>7593</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Imperforate anus -&gt; Colostomy</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>7/11/66</u> , 19 <u>66</u> , to <u>7/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/27</u> 19 <u>66</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Dr. Daniel S. Anderson</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7/27/66</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Daniel S. Anderson</u> 22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>July 29/1966</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>				
23d. LOCATION (City, town or county) <u>Salisbury, Maryland</u>					23e. (State) <u>Maryland</u>					24. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>				
25a. REC'D BY REGISTRAR <u>AUG 2 1966</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

Wisconsin

Marquette

Salisbury

Mar 11-10  
Village

511 Cooper Street

HOSPITAL

19

0

WY 8/1966

CHIEF

U S A

Salisbury, Maryland

Home

Home

Catherine Lee Hester

Richard Lee Hester

Mr. Richard Lee Hester (Father)  
511 Cooper St., Salisbury, Maryland

Home

Home

Medical Center, Salisbury, Maryland

Dr. Daniel S. Anderson

Salisbury, Maryland

Salisbury, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10680											
10683											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GIRDETREE</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>C.</u> Middle <u>Hauck</u> Last 4. DATE OF DEATH <u>July</u> Month <u>22</u> Day <u>1966</u> Year						5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>FEB 11, 1906</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>NEBRASKA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>PAUL HAUCK</u> 14. MOTHER'S MAIDEN NAME <u>CLARA H. GUTTMAN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW II</u> 16. SOCIAL SECURITY NO. <u>505-10-1627</u> 17. INFORMANT <u>THEO R. HAUCK, GIRDETREE MD.</u> Address						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Antropenture hemorrhage due to 451X</u> DUE TO (b) <u>atherosclerotic tear in abdominal aorta</u> DUE TO (c) <u>@ level of Superior Mesenteric artery</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anteropenture Anterior Aneurysm/resection - intact graft</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>0</u> p.m. <u>0</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Richard E. Hughes</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>RICHARD E. HUGHES MD</u> 22d. ADDRESS <u>MEDICAL CENTER, SALIS. MD</u>						22b. DATE SIGNED <u>7/27/66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>7/23/1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MAKEMIE PREBY.</u> 23d. LOCATION (City, town or county) (State) <u>SNOW HILL, MD.</u>						24. FUNERAL DIRECTOR <u>Dennis Funeral Home</u> ADDRESS <u>SNOW HILL, MD.</u> 25a. REC'D BY REGISTRAR <u>JUL 29 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10691					10684				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>22-1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mardela Springs</u> d. STREET ADDRESS <u>Rt. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Kim</u>			First <u>Kim</u> Middle <u>Hauton</u> Last <u>Hauton</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1966</u>		9. AGE (In years last birthday) <u>13</u> yrs. <u>13</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1966</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Oris Hauton</u>					14. MOTHER'S MAIDEN NAME <u>Gertrude Hopkins</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Oris Hauton - Rt. 1 Mardela Springs Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 7630 DUE TO (b) <u>SA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>William C. Morgan</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-6-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		23d. LOCATION (City, town or county) (State) <u>Mardela Springs Md</u>			
24. FUNERAL DIRECTOR <u>Loretta B. Jolley, Jersey Rd, Salis, Md</u>					25a. REC'D BY REGISTRAR <u>JUL 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		

6-220127



10088

10081

Handwritten notes, possibly including "June 20, 1881" and "Gentle's Map".

Handwritten notes at the bottom of the page, including "June 20, 1881" and "Gentle's Map".

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10692

## CERTIFICATE OF DEATH

10685

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>23</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>415 Pine Bluff Rd.,</u>				d. STREET ADDRESS <u>415 Pine Bluff Rd.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>Elizabeth</u> Last <u>Hearne</u>				4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1872</u>		
9. AGE (In years of birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clayton C. Parker</u>				14. MOTHER'S MAIDEN NAME <u>Maria Jane Leonard</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Miss. Elizabeth Hearne, Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Nov. 1958</u> to <u>July 23 1966</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>July 22 1966</u> , and that death occurred at <u>5:45 A</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>Thomas C. Hill Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/25/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL JR.</u>				22d. ADDRESS <u>415 Pine Bluff Road, Salisbury, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-25-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>		
24. FUNERAL DIRECTOR <u>Norman F. Baker</u>				ADDRESS <u>Salisbury, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 27 1966</u>		
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10083

10083

10083

10083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <span style="float: right;">c. LENGTH OF STAY IN 1b <u>55 Days</u></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital, Salisbury, Md.</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Caroline</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Preston</u> d. STREET ADDRESS <u>R. D. #1</u>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clifford Arthur Henney</u> First Middle Last <b>5. SEX</b> <u>Male</u> <span style="float: right;"><b>6. COLOR OR RACE</b> <u>White</u></span> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <span style="float: right;"><b>8. DATE OF BIRTH</b> <u>11-24-1899</u></span> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <span style="float: right;"><b>9. AGE</b> (In years last birthday) <u>66</u> yrs.</span>					<b>10. DATE OF DEATH</b> <u>7</u> <u>18</u> <u>1966</u> Month Day Year <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Philadelphia, Pa.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>						
<b>13. FATHER'S NAME</b> <u>Bernhard Henney</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline Knemeyer</u>					<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <span style="float: right;"><b>16. SOCIAL SECURITY NO.</b></span> <b>17. INFORMANT</b> <u>Margaret Henney</u> <span style="float: right;">Address same as #2</span>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary carcinoma of lung, rt. upper lobe</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>hrs.</u> <u>years ?</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>5/24</u> , 19 <u>66</u> , <b>to</b> <u>7/18</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>7/18</u> , 19 <u>66</u> , <b>and that death occurred at</b> <u>11:35 P.M.</u> , <b>from the causes and on the date stated above.</b>										<b>22b. DATE SIGNED</b> <u>7/19/66</u>	
<b>22a. SIGNATURE</b> <u>C. H. Winnacott, M.D.</u> <span style="float: right;"><b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/></span>					<b>22c. PHYSICIAN'S NAME (Type)</b> <u>C. H. Winnacott, M.D.</u> <span style="float: right;"><b>22d. ADDRESS</b> <u>Deer's Head State Hospital, Salisbury, Md.</u></span>						
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>July 23/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lakeview Memorial Park</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Camden County, N.J.</u>				
<b>24. FUNERAL DIRECTOR</b> <u>HOLLOWAY &amp; COMPANY</u> <span style="float: right;"><b>25a. REC'D BY REGISTRAR</b> <u>SALISBURY, MARYLAND</u></span>					<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>						

10055

10055

Winston

William

John

John

John

John

John

John

John

John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
10694					10687					
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>R.F.D. 1 box 38 Tyaskin</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>JULIA</u>		First Middle Last		4. DATE OF DEATH <u>HORSEY JULY 22 1966</u>		Month Day Year				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/1914</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Carr Handy</u>					14. MOTHER'S MAIDEN NAME <u>Julia Conway</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wesley Horsey Tyaskin Md.</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma to brain</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lung</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>7-15-</u> , 19 <u>66</u> , to <u>7-22-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-22-</u> 19 <u>66</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>James H. Clifford</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/22/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>James H. Clifford</u>					22d. ADDRESS <u>Medical Center Salisbury Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>7/26/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>New Town Md.</u>			
24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u>					ADDRESS <u>Salisbury Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
					DATE <u>AUG 1 1966</u>					



10083

10084

FILED MAR 31 1964  
FBI - MOBILE

FOR STATE  
HEALTH DEPT.

10695

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10688

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chester</b> 75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>715 N. Westover Circle</b>		d. STREET ADDRESS <b>224 Law St.</b>	
3. NAME OF DECEASED (Type or print) First <b>SAMMY</b> Middle <b>JAMES</b> Last <b>HORSEY</b>		4. DATE OF DEATH Month <b>7</b> Day <b>24</b> Year <b>66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1891</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Horsey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Savage</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>716-12-2486</b>	
17. INFORMANT <b>Sammy Horsey</b>		Address <b>715 Westover Cir. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Acute congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>July 26, 1966</b>	
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/30/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell</b>	23d. LOCATION (City or Town) (County) (State) <b>Hopewell Md.</b>
24. FUNERAL DIRECTOR <b>Clinton Stewart, Salisbury, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

80001

ATLAS OF THE UNITED STATES

100

100

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH-AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springhill Nursing Home</b>					d. STREET ADDRESS <b>Mt Hermon Road</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRIETTA ELIZABETH HOTTON</b>					4. DATE OF DEATH Month <b>JULY</b> Day <b>5th</b> Year <b>19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 2/1879</b>		9. AGE (In years last birthday) <b>86</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Guernsey Island England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Girard</b>					14. MOTHER'S MAIDEN NAME <b>Mary Ann LeTissier</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Cecil G. Hotton (Son)</b> Address <b>Mt Hermon Rd Salisbury, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cerebral Disease</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>6 mon</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Aug-7-1966</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. Lee Lawry</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>July 6/1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee Lawry</b>					22d. ADDRESS <b>315 N. Division St. Salisbury, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>July 7/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>JUL 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

HOLLAND & COMPANY, BALTIMORE, MARYLAND

Revised July 7, 1966

Parsons Cemetery

Baltimore, Maryland

Dr. Lee Lewis

315 N. Division St., Baltimore, Md.

July 1966

ADD-7:55A.

WVA

No

John Girard

1001 ELLIOTT HOME WORK

Female White

x

Aug. 2, 1979

86

July 11

HELENETTA ELIZABETH HOTTON

25

66

Springhill Nursing Home

14 Horton Road

Salisbury (Maryland)

Salisbury

Wicomico

Maryland

Wicomico

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>10697</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>10690</p> </div> </div>											
<p>1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> <span style="float: right;">MARYLAND</span></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u></p>					
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u></p>						<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SELBYVILLE</u></p>					
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u></p>						<p>d. STREET ADDRESS <u>RURAL</u></p>					
<p>3. NAME OF DECEASED (Type or print) First <u>VINA</u> Middle <u>A.</u> Last <u>HUDSON</u></p>						<p>4. DATE OF DEATH Month <u>JULY</u> Day <u>13</u> Year <u>1966</u></p>					
<p>5. SEX <u>FEMALE</u></p>		<p>6. COLOR OR RACE <u>WHITE</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>7-7-1877</u></p>		<p>9. AGE (In years last birthday) <u>89</u> yrs.</p>		<p>IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED STREETCAR</u></p>						<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>DELAWARE</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>	
<p>13. FATHER'S NAME <u>JAMES DERRICKSON</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>SALLY LEKITES</u></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u></p>						<p>16. SOCIAL SECURITY NO. <u>221-24-478</u></p>		<p>17. INFORMANT <u>ALBERT HUDSON, SELBYVILLE, Del.</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>4200</u> DUE TO (b) <u>Heart Disease</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c)</p>										<p>INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>7-13-66</u>, 19<u>66</u>, to <u>7-13-66</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>7-13-66</u> and that death occurred at <u>11 AM</u>, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE <u>William R. Goober</u></p>						<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>		<p>22b. DATE SIGNED <u>7-15-66</u></p>			
<p>22c. PHYSICIAN'S NAME (Type)</p>						<p>22d. ADDRESS</p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>23b. DATE THEREOF <u>7-16-66</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>LYNCHES CEMETERY</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>SELBYVILLE, DEL.</u></p>					
<p>24. FUNERAL DIRECTOR <u>Charles Nelson, Frankford, Del.</u></p>						<p>25a. REC'D BY REGISTRAR <u>JUL 21 1966</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>			



10000

10000

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10698

## CERTIFICATE OF DEATH

10691

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN lb <b>Since 9/10/65</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Goldsboro</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pine Bluff State Hospital</b>				d. STREET ADDRESS <b>RFD #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Talbert</b> Last <b>Irby</b>				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>June 14, 1897</b>		9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Campbell Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaiah Irby</b>				14. MOTHER'S MAIDEN NAME <b>Alice Holmes</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>228-03-3037</b>		17. INFORMANT <b>Records of Pine Bluff State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 10, 1965</b> , to <b>July 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 3, 19 66</b> , and that death occurred at <b>10:50 A.M.</b> causes and on the date stated above.							
22a. SIGNATURE <i>E. P. Ritchings</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>July 3, 1965</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings</b>				22d. ADDRESS <b>Pine Bluff State Hospital, Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 6, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crumpton Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Crumpton, Q.A.Co; Md.</b>	
24. FUNERAL DIRECTOR <b>Edward Fellows, Millington, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 7 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

10031

ESTIMATE OF DEATH

10031

Caroline

Maryland

from on

neighbors

since 10/10/03

relating

The first State Hospital

and of

Toliver

Vernon

Terry

Terry

x June 14, 1987 03

Male White

Campbell Co., Virginia

Lynchburg

Alice Holmes

Lynchburg

The first State Hospital

100-03-1007

Cotnam's Decision

Sept. 10 03 01:30 AM

July 3, 1988

10:30 AM

July 3, 1988

The first State Hospital

Lynchburg

Lynchburg

July, 1988

Lynchburg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10693					10692				
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Arlington</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>83-3</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Penixskla General</i>					d. STREET ADDRESS <i>638 North Greenbrier St.</i>				
3. NAME OF DECEASED (Type or print) <i>Errol R. Jenkins</i>					4. DATE OF DEATH <i>July 30 1966</i>				
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 24, 1918</i>		9. AGE (In years, last birthday) <i>48</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Funeral Director</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Funeral</i>			11. BIRTHPLACE (County & State, or foreign country) <i>St. Clair, Penn.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>									
13. FATHER'S NAME <i>Ralph B. Jenkins</i>					14. MOTHER'S MAIDEN NAME <i>Martha Crestwell</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>					16. SOCIAL SECURITY NO. <i>WW 11</i>		17. INFORMANT <i>Mary Lou Jenkins- Same as #2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> <i>330X</i> DUE TO (b) <i>Cerebral Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus, Arteriosclerotic Heart Disease</i>					INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>7/29</i> , 19 <i>66</i> , to <i>7/30</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7/29</i> , 19 <i>66</i> , and that death occurred at <i>1:45</i> AM, from the causes and on the date stated above.									
22a. SIGNATURE <i>David J. Gilmore</i>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <i>David J. Gilmore</i>					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>8/2/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat. Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Arlington, Virginia</i>		
24. FUNERAL DIRECTOR <i>Harold X. Murphy</i>					25a. REC'D BY REGISTRAR <i>AUG 3 1966</i>				
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

10005

Atkinson

Virginia

675 North Greenbrier St.

Feb. 24, 1948

St. Louis, Mo.

Merlin Greenwell

100-1-2075 (MEX) Don (MEX) - 100-1-2075

100-1-2075

Atkinson Nat. Lab., Atkinson, Virginia

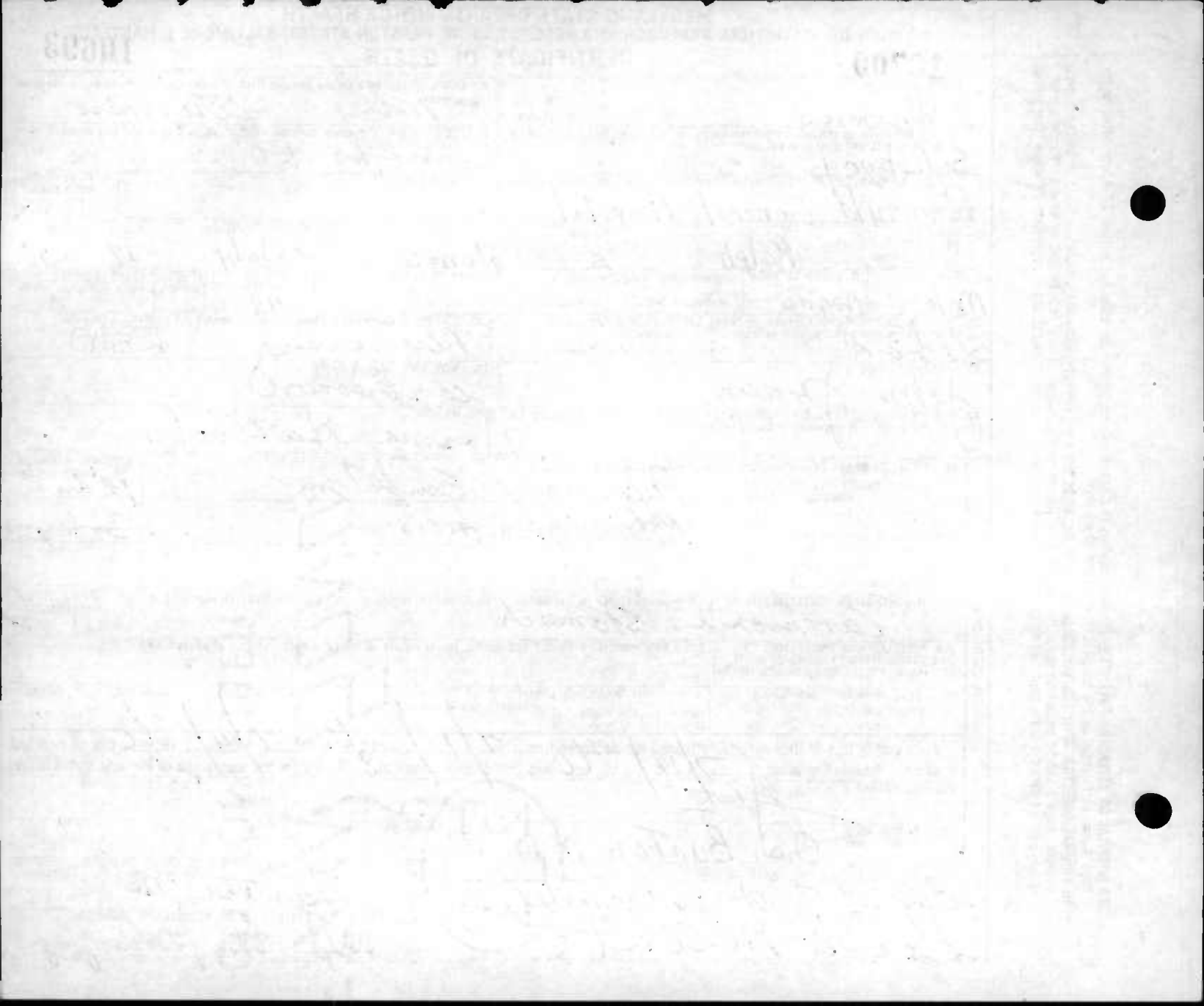
Atkinson Nat. Lab., Atkinson, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>S</u> Middle <u>Jones</u> Last			4. DATE OF DEATH <u>July</u> Month <u>14</u> Day <u>19</u> Year <u>66</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Jones</u>					14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>			16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Norma Hubbard</u> Address <u>  </u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism.</u> <u>466X</u> DUE TO (b) <u>Phlebotrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma Stomach</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1/66</u> , to <u>7/14/66</u> , that (I) (we) last saw the deceased alive on <u>7/14/66</u> , and that death occurred at <u>8 a.m.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) <u>D. Burton M.D.</u>	
				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>7-17-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loretta Cem</u>		23d. LOCATION (City, town or county) (State) <u>Loretta Md.</u>		
24. FUNERAL DIRECTOR <u>Decker M. West</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>JUL 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10701 Item 2 See Birth Cert. CERTIFICATE OF DEATH 10694											
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> ✓						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>					c. LENGTH OF STAY IN 1b <u>23-2</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>						
d. STREET ADDRESS <u>204 Broad Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH</u>					4. DATE OF DEATH Month Day Year <u>JULY 20 1966</u>						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 20 1966</u>		9. AGE (In years last birthday) Months Days Hours Min. <u>— — 3 5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>SALISBURY MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Bobby Joseph</u>					14. MOTHER'S MAIDEN NAME <u>CLARA L. PERDUE</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Bobby Joseph</u>			Address <u>Berlin MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>3:40</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>D. Anderson</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>DANIEL ANDERSON</u> 22d. ADDRESS 22b. DATE SIGNED 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>7/22/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>NEW HOPE</u> 23d. LOCATION (City, town or county) (State) <u>WILLARDS MD</u> 24. FUNERAL DIRECTOR <u>Anna A. Burboze</u> ADDRESS <u>Berlin Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>JUL 25 1966</u>											

6-220146

10034

10701

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are visible.]*

*[Faint, mostly illegible text at the bottom of the page, possibly bleed-through from the reverse side. Some words like "The" and "and" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>Happy Lane 313</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Clara</u>		First		Middle		Last		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1966</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 12, 1880</u>		9. AGE (in years last birthday) <u>85</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. STATE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Charlotte Sanford</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-18-6746</u>		17. INFORMANT <u>Louise Carter</u> Address <u>2227 Wharton St. Phila. Pa.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A. (large)</u> <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> (c) <u>Cerebro arteriosclerosis</u>									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. KIND OF INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>7/9/66</u> , 19 <u>66</u> , to <u>7/19/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/19/66</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above.										
22a. SIGNATURE <u>Carriz Heenan</u> M.D.								22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>CARRIZ HEENAN MD</u>								22d. ADDRESS <u>226 N. Duquesne St</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/24/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury Md.</u>				
24. FUNERAL DIRECTOR <u>Clinton F. Stewart Salisbury Md.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

50 0861:41.540

•

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10703					10696									
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>					d. STREET ADDRESS <u>705 JEWEL STREET</u>									
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Kirk</u> Last <u>Kirk</u>					4. DATE OF DEATH Month <u>JULY</u> Day <u>16</u> Year <u>1966</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-14-80</u>		9. AGE (In years last birthday) <u>85</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DELMAR-DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME <u>JOSEPH BEACH</u>					14. MOTHER'S MAIDEN NAME <u>SARAH ELLIS</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT Address <u>SARAH BANKS DELMAR-DEL</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>66</u> , to <u>7/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/16</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.														
22a. SIGNATURE <u>David J. Gilmore</u>					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>					22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>7-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. STEPHENS CEM</u>		23d. LOCATION (City, town or county) (State) <u>DELMAR-DEL</u>					
24. FUNERAL DIRECTOR <u>Charles W. Harrel</u>					25a. REC'D BY REGISTRAR <u>JUL 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		DATE					



10000

10000

*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10704

10697

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>9yrs. 10mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u> <u>09-2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Hannah</u> Last <u>Kral</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/30/1909</u> <u>56</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Kral</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Moyer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Louis Kral, East New Market, Md</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>14</u> days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Sclerosis - years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>56</u> , to <u>July 31</u> , 19 <u>66</u> , that (I)-(we) last saw the deceased alive on <u>July 31</u> , 19 <u>66</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>C.H. Winnacott</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/31/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>C.H. Winnacott, M.D.</u>				22d. ADDRESS <u>Deer's Head State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Deer's Head State Hospital</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) <u>Md</u>	
24. FUNERAL DIRECTOR <u>Keith S. Milborough, East New Market, Md</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1603

4050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

Item 18 Film G379 7/26/66  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Seaford</u> <u>Rural</u> <u>46-3</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene H. Lankford</u> First Middle Last 4. DATE OF DEATH <u>July 14 1966</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 21-1897</u> 9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Seaford Del.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Lankford</u> 14. MOTHER'S MAIDEN NAME <u>ANNIE Pusey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>221-244063</u> 17. INFORMANT <u>Mrs Elva H. Lankford, Seaford, Del.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion - acute</u> 451X DUE TO (b) <u>Aortic Aneurysm</u> DUE TO (c) <u>Abdominal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>6:17</u> , 19 <u>66</u> to <u>7:14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7:14</u> , 19 <u>66</u> , and that death occurred at <u>7:14</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>H. H. Briele</u> 22c. PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>		22b. DATE SIGNED <u>7-16-66</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Medical Center Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>July 18-1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> 23d. LOCATION (city, town or county) (State) <u>Seaford, Del.</u>		24. FUNERAL DIRECTOR <u>Harry E. Darby Seaford, Del.</u> 25a. REC'D BY REGISTRAR <u>JUL 19 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

1050

2002

1991-1992

1991

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

1991-1992

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D.O.A. Pen.Gen.Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>1904 N.Salisbury Blvd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PEARL MATILDA LAYFIELD</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>31</b> Year <b>1966</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 28/1918</b> 9. AGE (In years last birthday) <b>48</b> yrs. 3 Months 03 Days 00 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Wicomico Co., Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Henry Ellis</b>		14. MOTHER'S MAIDEN NAME <b>Annie Bell Dykes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-10-9722</b> 17. INFORMANT <b>Mrs. Edith E. Hubeny (Sister)</b> Address <b>1109 North Division St. Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia and bronchial asthma</b> 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>Aug. 2/1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 3/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>AUG 3 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10000

10000

Wisconsin

Wisconsin

Wisconsin

Sellsbury

Sellsbury

1904 N. Sellsbury Blvd

D.O.A. Pen. Gen. Hospital

68

31

July

WATLIDA - INVENTED

HEARD

3 03

48

N. Apr. 28/1918

Female White

U. S. A.

Wisconsin Co., Maryland

None

House work

Amel Bell Dykes

William Henry Ellis

214-10-9722 Division St. Sellsbury, Md.  
Rt. 2, Box 2, Sellsbury (Station) 1109 North

no

X X

Aug. 1966

X

Dr. Carl E. Royer  
409 Camden Ave. Sellsbury, Md.

Sellsbury, Maryland

British Aug. 3/1966 Parsons Cemetery

HOLWAY & COMPANY SELLSBURY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10707					10700				
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mapleshade Convalescent Home</b>					d. STREET ADDRESS <b>Rt # 1</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JENNIE</b>			First Middle Last <b>LECATES</b>		4. DATE OF DEATH <b>July 7, 1966</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Mar. 1, 1888</b> 9. AGE (In years last birthday) <b>78</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Whitesville, Del.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Cordrey</b>					14. MOTHER'S MAIDEN NAME <b>Ella Carmine</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>214-34-7386</b>		17. INFORMANT Address <b>Wm. J. LeCates, Delmar, Del.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June 24, 1966</b> , to <b>July 7, 1966</b> , that (I) (we) last saw the deceased alive on <b>7/7/66</b> 19, and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>H.S. Kuhlman</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/9/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. H.S. Kuhlman</b>					22d. ADDRESS <b>Sharptown, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>7-10-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>		23d. LOCATION (City, town or county) (State) <b>Laurel, Del.</b>		
24. FUNERAL DIRECTOR <b>Charles W. Marvel, Delmar, Del.</b>					25a. REC'D BY REGISTRAR <b>JUL 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10400

10700

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10708						10701					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN ID <u>5 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> d. STREET ADDRESS <u>213 Sixth Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>William Cleveland Mariner</u> First Middle Last						4. DATE OF DEATH <u>July 7 1966</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 10, 1891</u>		9. AGE (in years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OIL PRODUCTS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Accomack County, Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>GEORGE S. MARINER</u>						14. MOTHER'S MAIDEN NAME <u>MALISSA EAST</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>212-10-8397</u>		17. INFIRMANT <u>GEORGE L. MARINER, Pocomoke City, MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>1918</u> DUE TO (b) <u>ASCV Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Spondylosis Cerv CA Fract + Ect</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr</u> <u>2 Yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>58</u> , to <u>7/7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/7</u> , 19 <u>66</u> , and that death occurred at <u>4:10</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>John M. Bloxom III</u> 22c. PHYSICIAN'S NAME (Type) <u>J. M. BLOXOM III</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7-9-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FIRST BAPTIST</u>		23d. LOCATION (City, town or county) (State) <u>Pocomoke City, Maryland</u>			
24. FUNERAL DIRECTOR <u>Robert H. Watson</u> <u>ROBERT H. WATSON</u>						ADDRESS <u>Pocomoke City, MD.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	

10501

10501

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23-2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>Route # 1 Box 306</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE E. Martin</u>						4. DATE OF DEATH Month Day Year <u>July 15 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 9, 1905</u>		9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WORCESTER, MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES BRATTEN</u>						14. MOTHER'S MAIDEN NAME <u>SARA HOLLAND</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>						16. SOCIAL SECURITY NO. <u>215 16 3777</u>		17. INFORMANT Address <u>WILLIE MARTIN, Snow Hill, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 5272 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive failure</u> 2 wks (c) <u>Chronic Lung disease</u> ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>July</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>July 15</u> , 19 <u>66</u> and that death occurred at <u>8 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>David Rafat</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT MD.</u> 22d. ADDRESS <u>Snow Hill, Maryland</u> 22b. DATE SIGNED 23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>7/19/1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MT. WESLEY</u> 23d. LOCATION (City, town or county) (State) <u>Snow Hill, MD.</u> 24. FUNERAL DIRECTOR <u>SEWARD C. DENNIS</u> ADDRESS <u>DENNIS FUNERAL HOME, SNOW HILL, MD.</u> 25a. REC'D BY REGISTRAR <u>JUL 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>James Judge</u>											



10505

10505

RECEIVED

RECEIVED

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>Jersey Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>BENNY, JR. MASON</u>			First Middle Last		4. DATE OF DEATH Month <u>JULY</u> Day <u>31</u> Year <u>1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 30, 1966</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>2</u> Hours <u>3</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico-MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>BENNY MASON</u>					14. MOTHER'S MAIDEN NAME <u>FLORENCE WILSON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Benny Mason</u>			Address <u>Jersey Road</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Axeleration</u> <u>7625</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>26 hr. 37 min</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>66</u> , to <u>7/31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/31</u> , 19 <u>66</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.										
22a. SIGNATURE <u>D. S. Anderson</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/31/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>DANIEL ANDERSON</u>					22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>				
24. FUNERAL DIRECTOR <u>Arthur E. Stewart</u>					ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

6-220345

10501

10710

9

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and informally event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b> d. STREET ADDRESS <b>11th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RALPH STEWART MATHIAS, SR.</b>		4. DATE OF DEATH <b>July 9 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Products</b>	9. AGE (In years last birthday) <b>63 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Stewart Mathias</b>		14. MOTHER'S MAIDEN NAME <b>Emma Scott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-6616</b>	
17. INFORMANT <b>Mrs Iola Hill Mathias, Maryland</b>		Address <b>Pocomoke City,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Screening</b> <b>8254</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary spleen - Reticular hematoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:30 p.m. 6-21-1966</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. (City or town) (County) (State) <b>Pocomoke Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Robert H. Watson</b>		22. DATE SIGNED <b>7-11-66</b>	
EXAMINER'S NAME (Type) <b>Robert H. Watson</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-11-1966</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Fairview Lawn</b>
23d. LOCATION (City, town or county) (State) <b>Onancock, Virginia</b>		25a. REC'D BY REGISTRAR <b>JUL 13 1966</b>	
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

A1501

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10712

10705

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> 22-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Schumaker Pond D.O.A. Pen. Gen. Hospital</b>			d. STREET ADDRESS <b>213 A Davis Street</b>		
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>LEE</b> Last <b>MATTHEWS</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Child</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5/1956</b>	9. AGE (In years lost birthday) yrs. <b>10</b>	IF UNDER 1 YEAR Months <b>02</b> Days <b>09</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Unk</b>			14. MOTHER'S MAIDEN NAME <b>Virginia D. Moore</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT (Same as #2 and #14) Address <b>Mother</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Swimming in Pond</b>			
20c. TIME OF DEATH Month, Day, Year <b>3:45 (p.m.) 7/14/66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Schumaker Pond</b>		20f. (City or town) (County) (State) <b>Wicomico County, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>409 Camden Ave. Salisbury, Maryland</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <b>July 16 /1966</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 16/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hebron Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>			25a. REC'D BY REGISTRAR <b>JUL 18 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



10705

Wisconsin

Henry James

James

James

Henry James

James

James

66

James

James

James

James

66

James

James

James

James

James

66

James

James

James

James

James

James

James

James

James

James

James

66

James

James

James

James

James

James

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10706

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Peninsula General Hospital</b>		d. STREET ADDRESS <b>726 Delaware Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>JANET</b> Middle <b>MENTSON</b> Last <b>MENTSON</b>		4. DATE OF DEATH Month <b>7</b> Day <b>17</b> Year <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April, 1966</b>
9. AGE (In years lost birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>17</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Janet Burris</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Menson</b>		14. MOTHER'S MAIDEN NAME <b>Janet Burris</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Isaac Menson Del. Ave. Salis Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO (b) <b>Aspiration of Vomitus</b> (c) <b>(Sudden death in infancy)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found not breathing in crib.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6</b> Hour a.m. <b>7-17-66</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Own home</b>	20f. (City or town) (County) (State) <b>Salisbury, Wicomico, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>July 21, 1966</b>	
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/21/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>green acres</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Md.</b>
24. FUNERAL DIRECTOR <b>Walter F. Stewart</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 27 1966</b>	
ADDRESS <b>Salis Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1943

1943

THE UNIVERSITY OF CHICAGO

CHICAGO, ILL.

TO THE PRESIDENT OF THE UNIVERSITY OF CHICAGO

1943-44

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

80

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>DEL MAR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>ELIZABETH</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA ELIZABETH Mills</u>		4. DATE OF DEATH <u>July 27 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EBENEZER WHITE</u>		14. MOTHER'S MAIDEN NAME <u>ROSA A. BORDY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>EUGENE MILLS</u>		Address <u>DEL MAR - MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Large left leg (amputation)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/16</u> , 19 <u>66</u> , to <u>7/27</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>7/27</u> 19 <u>66</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>7-27-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-30-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST STEPHENS</u>		23d. LOCATION (City, town or county) (State) <u>DELMAR DEL</u>	
24. FUNERAL DIRECTOR <u>Charles H. Marul</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>JUL 29 1966</u>			

10307

10311

Wisconsin

St. Joseph's Hospital  
St. Joseph's Hospital  
St. Joseph's Hospital

St. Joseph's Hospital  
St. Joseph's Hospital  
St. Joseph's Hospital

St. Joseph's Hospital  
St. Joseph's Hospital  
St. Joseph's Hospital

St. Joseph's Hospital  
St. Joseph's Hospital  
St. Joseph's Hospital

St. Joseph's Hospital  
St. Joseph's Hospital  
St. Joseph's Hospital

St. Joseph's Hospital  
St. Joseph's Hospital  
St. Joseph's Hospital

St. Joseph's Hospital  
St. Joseph's Hospital  
St. Joseph's Hospital

St. Joseph's Hospital  
St. Joseph's Hospital  
St. Joseph's Hospital

St. Joseph's Hospital  
St. Joseph's Hospital  
St. Joseph's Hospital

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Hebron <del>XXXXXX</del> Box#457 22-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen.Gen.Hospital</b>		d. STREET ADDRESS <b>Walnut Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANKLIN WILSON MILLS</b>		4. DATE OF DEATH Month Day Year <b>JULY 17th 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept.19/1918</b>
9. AGE (In years lost birthday) yrs. <b>47</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Talbot Mills</b>		14. MOTHER'S MAIDEN NAME <b>Ola Kennerly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-5439</b>	
17. INFORMANT <b>Mrs. Madora H. Mills (Wife)</b>		Address <b>Box#457 Walnut St. Hebron, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decomposed left coronary artery</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Philip A. Insley-Salisbury, Md.</b>		22. DATE SIGNED <b>2-18-66</b>	
EXAMINER'S NAME (Typed)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Burial</b>	<b>July 20/66</b>	<b>Hebron Cemetery</b>	<b>Hebron, Maryland</b>
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 22 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



10708

117

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> <u>19-2</u> d. STREET ADDRESS <u>214 W. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>James Lee Mister</u> First Middle Last						4. DATE OF DEATH <u>July 24 1966</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1940</u>		9. AGE (In years) <u>26</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Crisfield, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James E. Mister</u>						14. MOTHER'S MAIDEN NAME <u>Floris Landon</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Floris Mister, Same as 2. 1bcd</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>260x</u> DUE TO (b) <u>Diabetic Nephropathy &amp; Cardiopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Uremia</u>								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/19, 1966</u> to <u>7/24, 1966</u> , that (I) (we) last saw the deceased alive on <u>7/24, 1966</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>William D. Gray, MD</u>						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>William D. Gray</u>			
22d. ADDRESS <u>Salisbury, Md.</u>						22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Crisfield, Md.</u>		
24. FUNERAL DIRECTOR <u>Bradshaw &amp; Sons, Crisfield, Md.</u>						25a. REC'D BY REGISTRAR <u>AUG 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10000

STATE OF NEW YORK

10000

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

Wicks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10717 Item 7 Film G379 7/26/66 mh 10710											
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Somerset						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					c. LENGTH OF STAY IN 1b 19-2						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS Wenona						
3. NAME OF DECEASED (Type or print) Thelma					4. DATE OF DEATH Month July Day 17 Year 1966						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 66 yrs.		9. AGE (In years last birthday) 66 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Somerset Co; Md			
13. FATHER'S NAME Charles Daniels					14. MOTHER'S MAIDEN NAME Alice Jones						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Mervin Mister, Deal Island Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from July 7, 1966, to July 17, 1966, that (I) (we) last saw the deceased alive on July 17, 1966, and that death occurred at 1:00 PM, from the causes and on the date stated above.											
22a. SIGNATURE Thomas C. Hill Jr.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/17/66				
22c. PHYSICIAN'S NAME (Type) THOMAS C. HILL, Jr.					22d. ADDRESS Pine Bluff Road, Salisbury, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/19/1966		23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City, town or county) (State) Deal Island Md.				
24. FUNERAL DIRECTOR James Herman Precious					ADDRESS Md		25a. REC'D BY REGISTRAR DATE JUL 20 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

1011

UNITED STATES OF AMERICA

1011

2. 10. 1911

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

1011

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Dagsboro</b> 46-3	
3. NAME OF DECEASED (Type or print) <b>George Allen Murray</b>		4. DATE OF DEATH <b>7-13-66</b> 19 <b>66</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-26-48</b>
9. AGE (In years last birthday) <b>17</b> yrs.		IF UNDER 1 YEAR <b>19</b> Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EARIS MURRAY</b>		14. MOTHER'S MAIDEN NAME <b>JEANITA MURRAY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>22-32-317</b>	
17. INFORMANT <b>EARIS MURRAY</b>		Address <b>DAGSBORO DEL.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>9365</b> IMMEDIATE CAUSE (a) <b>Fractured skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple fractures of pelvis and extremities</b> (c) <b>DUE TO</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found dead on road.</b>	
20c. TIME OF INJURY Month, Day, Year <b>12-30 A.M. 7-13-66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road- Rt. 610</b>		20f. (City or town) (County) (State) <b>Whayleysville Wor. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		22. DATE SIGNED <b>7-16-66</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>409 Camden Ave. Salisbury, Md.</b>		23a. LOCATION (City or Town) (County) (State) <b>CLARKSVILLE SUSSEX DEL.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-19-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. GEORGES</b>		23d. REC'D BY REGISTRAR <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>A. Douglas Nelson, Frankford, Del.</b>		25a. DATE <b>JUL 20 1966</b>	



1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

1041

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

10719

10712

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b> 23-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Keyser Pt. Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WILKES</b> Last <b>MURRAY</b>				4. DATE OF DEATH Month <b>7</b> Day <b>28</b> Year <b>66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 2, 1908</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>		11. IF UNDER 24 HRS. Hours <b>5</b> Min. <b>5</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EMPLOYED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ICE PLANT</b>		11. BIRTHPLACE (State or foreign country) <b>WILKES BARRE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>JOSEPH A. MURRAY</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH DAVIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WORLD WAR II</b>				16. SOCIAL SECURITY NO. <b>216-07-4140</b>		17. INFORMANT <b>Mrs. GEORGE W. MURRAY</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage mid brain</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Hours
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>				22. DATE SIGNED <b>July 29, 1966</b> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/31/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BARRETT'S CHAPEL</b>		23d. LOCATION (City or Town) (County) (State) <b>FREDERICA DEL.</b>	
24. FUNERAL DIRECTOR <b>Burbage Funeral Home, Berlin, Md.</b> <b>Anna A. Burbage</b>				25a. REC'D BY REGISTRAR <b>AUG 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1918

UNITED STATES DEPARTMENT OF AGRICULTURE

1918

1918

*Handwritten signature*

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10720

CERTIFICATE OF DEATH

10713

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsborg, Rt. 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>TRENE</b> Last <b>NIBLETT</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Farmer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>223-32-1596</b>	
17. INFORMANT <b>Deer's Head State Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pyelonephritis</b> <b>605x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic cystitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the cervix 171x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>  <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/26/64</b> , 19 to <b>7/29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/29</b> , 19 <b>66</b> , and that death occurred at <b>3:34 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Winnacott</b>		22b. DATE SIGNED <b>7/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Winnacott</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-31-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Memory Gds</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Md.</b>
24. FUNERAL DIRECTOR <b>Charles W. Marvel, Delmar, Del.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 1 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10713

10713

FEDERAL BUREAU OF INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

XEROX

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

5-1-1983

USA

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
3. NAME OF DECEASED (Type or print) First <u>VIRGINIA</u> Middle <u>B.</u> Last <u>Payne</u>		d. STREET ADDRESS <u>1408 Philadelphia Road</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6, 1879</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver A. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Harriette E. Townsend</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Harriette Smith, 1408 Philadelphia Rd.</u>		Address <u>Joppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (2)</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Disease.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>6/7/66</u> <u>7/6/66</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/7/66</u> , to <u>7/6/66</u> , that (I) (we) last saw the deceased alive on <u>7/6/66</u> , and that death occurred at <u>6:45</u> P.M. from the causes and on the date stated above.		22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>O.S. Burton M.D.</u>		22b. DATE SIGNED <u>July 6, 1966</u>	
22d. ADDRESS <u>Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 9, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Joppa Harford Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md.</u>		25a. REC'D BY REGISTRAR <u>21009</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>JUL 8 1966</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10722					10715				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>6 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY - RT- #522-1</u>				d. STREET ADDRESS <u>HIGH BANKS</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>Edward</u> Last <u>PERRY</u>					4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1966</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10, 1898</u>		9. AGE (In years, last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>RET. PHOTOGRAPHER COMMERCIAL</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ROLAND PERRY</u>					14. MOTHER'S MAIDEN NAME <u>ANNIE MELVIN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>214-10-8567</u>		17. INFORMANT <u>MRS. J.E. PERRY</u>		Address <u>SEE-2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonitis</u> <u>5272</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic obstructive pulmonary disease</u> (c) <u>  </u>									INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>4 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-22</u> , 19 <u>66</u> , to <u>7-27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-27</u> , 19 <u>66</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>John G. Bulkeley</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-27-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN G. BULKELEY</u>					22d. ADDRESS <u>MEDICAL CENTER - SALISBURY, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/24/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMET.</u>		23d. LOCATION (City, town or county) (State) <u>SALISBURY, MD.</u>			
24. FUNERAL DIRECTOR <u>Edgar C. Hill</u>					ADDRESS <u>Salisbury, MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

10115

12723

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10723					10716				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Wicomico</b>					a. STATE <b>Delaware</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					b. COUNTY <b>Sussex</b>				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rehoboth</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>John B. Parsons Home For The Aged</b>					d. STREET ADDRESS <b>Bay Vista</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
<b>EDNA</b>			<b>POWERS</b>			<b>July 22</b>		<b>19 66</b>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
<b>Female</b>	<b>White</b>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>May 14, 1888</b>	<b>78</b> yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ulysis Melson</b>					14. MOTHER'S MAIDEN NAME <b>Eliza Carmine</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Lucy Powers, Rehoboth, Del.</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>July 22, 1966</b> to <b>7-26, 1966</b> , that (I) (we) last saw the deceased alive on <b>7-22, 1966</b> , and that death occurred at <b>PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>W. B. Smith</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-25-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>					22d. ADDRESS <b>Salisbury, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>7-25-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Stephens Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Delmar, Del.</b>		
24. FUNERAL DIRECTOR <b>Charles W. Marvel, Delmar, Del.</b>					25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>		

10418

11123

11123

11123

John T. ...

John T. ...

11123

11123

11123

11123

11123

11123

11123

11123

11123

11123

11123

11123

11123

11123

11123

11123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PENINSULA GENERAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DELAWARE</b> b. COUNTY <b>SUSSEX</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLENDALE</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>KATH RINE E PRETTYMAN</b>						4. DATE OF DEATH <b>July 3 1966</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-27-1897</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALTER P McCABE</b>						14. MOTHER'S MAIDEN NAME <b>ELIZABETH K COLLINS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>221-24-3239</b>		17. INFORMANT <b>ELSIE BUNTING</b> Address <b>SALISBURY MD</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 4301 DUE TO (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>10 hrs</b> <b>10 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1965</b> to <b>July 1966</b> , that (I) (we) last saw the deceased alive on <b>7/3 1966</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Refus S. Gardner Jr</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <b>7/3/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Refus S. Gardner Jr</b>						22d. ADDRESS <b>MEDICAL CENTER, SALISBURY MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>7-6-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ODD FELLOWS</b>			23d. LOCATION (City, town or county) (State) <b>MILFORD, DEL</b>			
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>JUL 11 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



10715

10715

HOLLAND & COMPANY, BARRISBURGH, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10725

10718

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>since 7/21/66</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pine Bluff State Hospital</b>		d. STREET ADDRESS <b>695 Fitzwater Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>-</b> Last <b>Pruitt</b>		4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Separated</b>	8. DATE OF BIRTH <b>Mar. 24, 1900</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Separated</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bud Pruitt</b>		14. MOTHER'S MAIDEN NAME <b>Stella Pruitt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>256-09-5041</b>	
17. INFORMANT <b>Mary Ellis</b>		Address <b>Records of Pine Bluff State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary Tuberculosis 0021</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>July 21</b> , 19 <b>66</b> , to <b>July 26</b> , 1966, that <del>he</del> (we) last saw the deceased alive on <b>July 26</b> , 19 <b>66</b> , and that death occurred at <b>10:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>E. P. Ritchings</b>		22b. DATE SIGNED <b>July 26, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-30-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Va</b>	23d. LOCATION (City or Town) (County) (State) <b>Wicomico Va</b>
24. FUNERAL DIRECTOR <b>Becker M. West</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 3 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1938

DEPARTMENT OF HEALTH

10718

Almonico

Maryland

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

Almonico

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10726

10719

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>2 Hrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		22.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>225 Shad Point Rd.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>PRYOR</b>		4. DATE OF DEATH Month <b>7</b> Day <b>15</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1901</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Tanker</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John B. Pryor</b>		14. MOTHER'S MAIDEN NAME <b>Ella Hobbs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>181-05-1216</b>	
17. INFORMANT <b>Mr. Wm. E. Pryor</b>		<b>1257 Kerlin St., Chester, Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral &amp; hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>essential hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day 2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>65</b> , to <b>7/15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/15</b> , 19 <b>66</b> , and that death occurred at <b>6:21</b> M, from causes and on the date stated above.			
21a. SIGNATURE <b>Dr. Earl Beardsley</b>		21b. DATE SIGNED <b>7-18-1966</b>	
21c. PHYSICIAN'S NAME (Type) <b>Dr. Earl Beardsley</b>		21d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/18/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Union Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wicomico County, Maryland</b>	
24. FUNERAL DIRECTOR <b>Norman T. Baker</b> <b>Hill Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1552

STATE OF TEXAS

10110

County of ...

City of ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

*Central & Southern  
Central & Southern*

*for*

*Wm. B. ...*

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<div style="display: flex; justify-content: space-between;"> <span>10727</span> <span>Item 9 Film 8379</span> <span>10720</span> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEALS ISLAND 192</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>GEORGE</u> Middle <u>H.</u> Last <u>Richardson</u>						<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>13</u> Year <u>1966</u>					
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MAR. 24 1895</u>		<b>9. AGE</b> (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>BARBER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SELF EMP.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BERLIN MD (MD)</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>			
<b>13. FATHER'S NAME</b> <u>ANDREW RICHARDSON</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>ELEANOR POWELL</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>No</u>						<b>16. SOCIAL SECURITY NO.</b> <u>46-09-5902</u>		<b>17. INFORMANT</b> Address <u>Mr. HARPER RICHARDSON, BERLIN MD</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ALL PNEUMONIA</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 DAYS</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>LEFT ATRIAL WALL CARCINOMA</u>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>6/24</u>, 19<u>66</u>, to <u>7/13</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>7/13</u>, 19<u>66</u>, and that death occurred at <u>10:15</u> AM, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>D.M. Barker</u>						<b>22b. DATE SIGNED</b> <u>7/14/66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>D.M. Barker</u>			
<b>22d. ADDRESS</b>						<b>22e. ADDRESS</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>7/16/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>EVERGREEN</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>BERLIN MD</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Ann P. Purchase Berlin Md</u>						<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			
<b>DATE</b> <u>JUL 18 1966</u>											



10401

RECEIVED OF DEPT

10401

RECEIVED  
10401

RECEIVED  
10401

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
10723												
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> 22-1				d. STREET ADDRESS <b>R.D.#2</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pen.Gen.Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>VIRGINIA</b> Middle <b>CAROLYN</b> Last <b>SHOCKLEY</b>						4. DATE OF DEATH <b>JULY</b> 14th 1966						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb.23/1914</b>		9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>04</b> Days <b>21</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee-Shirt Factory-Packer</b>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Larry Collins</b>						14. MOTHER'S MAIDEN NAME <b>Clara LeCates</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address: <b>Mr. Preston E. Shockley, Jr. (Husband)</b> <b>R.D.# 2 Salisbury, Maryland</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia.</b> <b>1950</b> DUE TO (b) <b>Plural effusion.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Lymphatic obstruction by metastatic adenocarcinoma.</b>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <b>April</b> <b>App-6-1966</b> to <b>7-14</b> , 1966, that (I) (we) last saw the deceased alive on <b>7-14</b> 1966, and that death occurred at <b>20P</b> M, from the causes and on the date stated above.												
22a. SIGNATURE <b>Stedman W. Smith</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>July 15/1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Stedman Smith</b>						22d. ADDRESS <b>Salisbury, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)						
<b>Burial</b>		<b>July 18/1966</b>		<b>Springhill Mem.Gardens</b>		<b>Salisbury, Maryland</b>						
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>						ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JUL 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10151

758

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

66

June

July

Shookley

Shookley

Shookley

July 21

July 22

July 23/1915

Female White

U S A

Salisbury, Maryland

Employee-Ship Secretary-Packer

Chief Lecturer

Harry Collins

Mr. Preston E. Shookley, Jr. (Husband)  
10151 Salisbury, Maryland

Aug-6:204

July 2, 1915

Salisbury, Maryland

Dr. Steadman Smith

First July 18, 1915 Springfield Mass. General Salisbury, Maryland

HOLLIDAY & COMPANY SALISBURY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
107228					107228						
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Delaware</i> b. COUNTY <i>✓</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Selbyville</i> 463						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>					d. STREET ADDRESS <i>Rt. 2 Box 197</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William Thomas Showell</i>			First Middle Last		4. DATE OF DEATH <i>July 23 1966</i>		Month Day Year		1966		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-25-1896</i>		9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Delaware</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Jacob Showell</i>					14. MOTHER'S MAIDEN NAME <i>Atlanta Harmon</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic abscesses</i> <i>585X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cholangitis</i> (c)										<i>unknown</i> <i>n</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Anemia</i>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>7/19 66</i> , 19 <i>66</i> to <i>7/23 66</i> , that (I) (we) last saw the deceased alive on <i>7/23 1966</i> , and that death occurred at <i>4:20</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Charles J. Moore</i>					ATTENDING PHYS. <input type="checkbox"/> M.D. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
<i>Burial</i>			<i>7-28-66</i>		<i>Whaleville Church Cem.</i>		<i>Whaleville, Md.</i>				
24. FUNERAL DIRECTOR <i>Loretta D. J. My. Jersey Pk. Sales</i>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles J. Moore</i>				

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1										M									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										10723									
10730										10723									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hoopersville</u> <u>09.2</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. LENGTH OF STAY IN 1b <u>1691 days</u>					d. STREET ADDRESS <u>None</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital, Salisbury, Md.</u>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Oliver J. Simmons</u>					4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>1966</u>														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1889</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u>48</u> Min. <u>0</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>George Simmons</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Insley</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>Unknown</u>					17. INFORMANT Address <u>Mrs Elizabeth R. Simmons, Hoopersville, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident, recurrent</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis Cardio Vascular disease</u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> , <u>1961</u> to <u>7/23</u> , <u>1966</u> , that (I) (we) last saw the deceased alive on <u>7/23</u> , <u>1966</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>A. C. Mitchell</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED <u>7/25/66</u>									
22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M.D.</u>					22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Jul 26, 1966</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>					23d. LOCATION (City, town or county) (State) <u>Cambridge, Maryland</u>				
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service, Cambridge, Maryland</u>					ADDRESS <u></u>					25a. REC'D BY REGISTRAR <u>JUL 27 1966</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



050.

67 1, 2, 3

1000000

George Wilson

10. The following information is for your information only:

2000

1999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10731					10724				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Wicomico			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Mardela Springs - Rural			b. COUNTY		Wicomico		
c. LENGTH OF STAY IN 1b		50 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Mardela Springs - Rural		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
San Domingo					San Domingo				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last Blonnie Harriet Smiley					Month Day Year July 16 19 66				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		Negro		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		August 8, 1900		65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Housework			Home		Sussex Co., Delaware			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
James Hoverton					Jannie Deshield				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
No			None		J. Milton Smiley, Mardela Springs, Md., RFD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7824 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure (c) Sudden death								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1966, 1966, that (I) (we) last saw the deceased alive on July 17, 1966, and that death occurred at 3:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE J. D. Quinn M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 18, 1966	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS Mardela Springs, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		July 20, 1966		Zion Church Cemetery		Near Sharptown, Maryland			
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland						25a. REC'D BY REGISTRAR DATE JUL 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

10754

10754

Location

Location

Location

Harold's - Rural

30 years

Harold's - Rural

on road

San Diego

July 15

July 15

Harold's

Harold's

03

August, 1970

August, 1970

August, 1970

1970

Harold's - Rural

Harold's

Harold's

Harold's - Rural

Harold's - Rural

Harold's - Rural, Harold's - Rural, Harold's - Rural

Harold's

Harold's

July 15, 1970

July 15, 1970

July 15, 1970

July 15, 1970

July 15, 1970

July 15, 1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10732

CERTIFICATE OF DEATH

10725

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRUITLAND</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRUITLAND</b>		221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>E. MAIN ST.,</b>				d. STREET ADDRESS <b>E. MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>SMITH</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>11</b> Year <b>1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>SEPT. 20, 1880</b>		9. AGE (In years lost birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS SMITH</b>				14. MOTHER'S MAIDEN NAME <b>JULIA JONES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>*****</b>		17. INFORMANT <b>MRS. THOMAS J. SMITH</b>		Address <b>SEE 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> <b>As seen under Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4200</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-</b> , 19 <b>66</b> , to <b>7-11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-11</b> , 19 <b>66</b> , and that death occurred at <b>7-11</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>WILB ER R. ELLIS, JR</b>		22c. PHYSICIAN'S NAME (Type) <b>WILB ER R. ELLIS, JR MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>MEDICAL CENTER, SALISBURY, MARYLAND</b>		22b. DATE SIGNED <b>7-13-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/13/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WICOMICO MEM. PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>SALISBURY, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Harold H. Hiegl, Jr. Salisbury, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

1038

38701

Listed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1 (M)

90

(I)

0

1

100

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10733

# CERTIFICATE OF DEATH

10726

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>			c. LENGTH OF STAY in lb <b>1 yr.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>			22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING HILL PR. SANI.</b>				d. STREET ADDRESS <b>725 CAMDEN AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLOTTE</b> Middle <b>COLLINS</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>1966</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 17, 1904</b>		9. AGE (In years last birthday) yrs. <b>62</b>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ROLLIN P. COLLINS</b>				14. MOTHER'S MAIDEN NAME <b>NELLIE CANNON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>SETH C. TAYLOR</b>		Address <b>SEE 2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic CA</b> <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>C.A. left breast</b> (c) <b>3 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4-5</b> , 19 <b>65</b> , to <b>7-14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-13</b> , 19 <b>66</b> , and that death occurred at <b>5 A</b> M, from causes and on the date stated above.								
22a. SIGNATURE <b>Earl L. Royer</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <input type="checkbox"/>		22b. DATE SIGNED <b>7-14-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>EARL L. ROYER</b>		M.D. <b>M.D.</b>		22d. ADDRESS <b>CAMDEN AVE., SALISBURY, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/16/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ODDFELLOW'S CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BISHOPVILLE</b>			
24. FUNERAL DIRECTOR <b>George C. Royer</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 20 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL		d. STREET ADDRESS MAIN ROAD	
3. NAME OF DECEASED (Type or print) First NORRIS Middle TAYLOR Last TAYLOR		4. DATE OF DEATH JULY 14 1966	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 21 - 1915	
9. AGE (In years, last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BRINKLEY		14. MOTHER'S MAIDEN NAME LULY WILSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes W.W.II		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Mrs. Elizabeth Taylor		Address Wenona Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) Myocardial Infarct		INTERVAL BETWEEN ONSET AND DEATH 17	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-21, 1966, to 7-14, 1966, that (I/we) last saw the deceased alive on 7-14, 1966, and that death occurred at 7:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE Wesley R. [Signature]		22b. DATE SIGNED 7-14-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR L. G. Webster Princess Anne		25a. REC'D BY REGISTRAR JUL 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10737

10737

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

17 days

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>										
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Somerset</u></span>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>79 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upper Fairmount</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital, Salisbury, Md.</u>					d. STREET ADDRESS <u>19-2</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>First Reuben Middle Rathbun Last Townroe</u>			<b>4. DATE OF DEATH</b> <u>Month July Day 14 Year 1966</u>							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 9, 1886</u>		<b>9. AGE (In years last birthday)</b> <u>80 yrs.</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Industrial Engineer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Canada</u>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Canada</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		
<b>13. FATHER'S NAME</b> <u>Frederick Townroe</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Rose Rathbun</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)			<b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service)		<b>17. INFORMANT</b> <u>John Townroe; 4101 San Jacinto Houston, Texas</u>					
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> DUE TO (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6-8 hours</u> <b>Years</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)</b> <u>Diabetes mellitus; Ca of large bowel with resection - colostomy.</u>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>			<b>(County)</b>			<b>(State)</b>				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/26</u> , 19 <u>66</u> , <b>to</b> <u>7/14</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>7/14</u> , 19 <u>66</u> , <b>and that death occurred at</b> <u>12:20</u> , <b>from the causes and on the date stated above.</b>										
<b>22a. SIGNATURE</b> <u>Charles H. Winnacott</u>					<b>M.D.</b>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>7/14/66</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Charles H. Winnacott, M.D.</u>					<b>22d. ADDRESS</b> <u>Deer's Head State Hospital, Salisbury, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>7/17/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Andrews</u>		<b>23d. LOCATION (City, town or county)</b> <u>Princess Anne, Md.</u>			<b>(State)</b>
<b>24. FUNERAL DIRECTOR</b> <u>James L. Luman</u>					<b>ADDRESS</b> <u>Princess Anne, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>JUL 19 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

10753

10753

John (James) Thompson, Texas  
Also an American  
Home Address

Production Company

10753

10753

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10736

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10729

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and on any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>197 Pierce Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>TRADER</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>7th</b> Year <b>66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2/1892</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk - Clothing Store</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Jesse Overton Bernard</b>				14. MOTHER'S MAIDEN NAME <b>Annie Crawford</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Stanley V. Trader (Husband)</b> Address <b>107 Pierce Avenue Salisbury, Maryland 21801</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes - Fracture femur - arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped + fell at home</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6/30</b> 19 <b>66</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Salisbury Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Philip A Instey</b>		EXAMINER'S NAME (Type) <b>Philip A Instey</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>7-8-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>Burial</b>		<b>July 9/1966</b>		<b>Parsons Cemetery</b>		<b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



10732

10732

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1D <u>2621 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		d. STREET ADDRESS <u>802 Delaware Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Harrison</u> Last <u>Whaley</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>22</u> Year <u>19 66</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6-7-1898</u>	
<b>9. AGE</b> (In years last birthday) <u>68 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Wicomico</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>James Washington Whaley</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Jane Wooden</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>Percey Joseph Whaley</u>		<b>Address</b> <u>Salisbury 403 Lake St.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, left lower lobe, marked</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 days</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 19</u> , 19 <u>59</u> , to <u>July 22</u> , 19 <u>66</u> , that <u>XX</u> (we) last saw the deceased alive on <u>July 22</u> , 19 <u>66</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Andrew C. Mitchell</u>				<b>22b. DATE SIGNED</b> <u>8:10 P.M. 7/25/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>A. C. Mitchell, M. D.</u>	
<b>22d. ADDRESS</b> <u>Deer's Head State Hospital; Salisbury, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>7-27-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Acres</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Salisbury, Md.</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Soretha B. Jolley-Jersey Rd. Rt #2 Salis.</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>AUG 1 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. J...</u>	

BP

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

1075

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/66

FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Life time</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ERNEST LINWOOD WHITE</b>		4. DATE OF DEATH Month Day Year <b>July 9 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/9/27</b>
9. AGE (In years last birthday) yrs. <b>38</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Salesman</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset County Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Ernst Linwood White Sr</b>	
14. MOTHER'S MAIDEN NAME <b>Harriett Ballard</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WW II</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Ernest L White Sr. Westover, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination from gunshot wounds of</b> <b>981X</b> DUE TO <b>both upper legs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Walked in tavern - was shot in both legs with</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>10:20 7/9 19 66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work <b>Stetons Tavern</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Princess Anne Som. Md.</b>		20f. (City or town) (County) <b>shotgun</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>7/18/66</b>	
ACTUAL SIGNATURE <b>Philip A. Insley</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <b>1103 Main St., Salisbury Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/16/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		23d. LOCATION (City or Town) (County) (State) <b>Cottage Grove, Md.</b>	
24. FUNERAL DIRECTOR <b>William H. James Jr, Princess Anne, Md</b>		25a. REC'D BY REGISTRAR <b>JUL 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

10731

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10733					10732						
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> ✓						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wallops Road</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>					d. STREET ADDRESS <u>83-3</u>						
3. NAME OF DECEASED (Type or print) <u>William Willis Williams</u> First Middle Last					4. DATE OF DEATH <u>July 23 1966</u> Month Day Year						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13 1906</u>		9. AGE (In years last birthday) <u>60</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>John A. Williams</u>					14. MOTHER'S MAIDEN NAME <u>Laura Collins</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>230-07-0709</u>			17. INFORMANT <u>Evelyn Williams Wallops, Virginia</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic cirrhosis &amp; liver failure</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic glomerulonephritis &amp; renal insufficiency</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>7-18-1966</u> , to <u>7-23-1966</u> , that (I) (we) last saw the deceased alive on <u>7-23 1966</u> , and that death occurred at <u>12:34</u> M, from the causes and on the date stated above.										21b. DATE SIGNED <u>7/23/66</u>	
22a. SIGNATURE <u>James L. Clifford</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/23/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>James L. Clifford</u>					22d. ADDRESS <u>MEDICAL CENTER SALISBURY, MD</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>July 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Downing Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Oak Hall, Virginia</u>			
24. FUNERAL DIRECTOR <u>Salzer Funeral Home, Chincoteague, Virginia</u>					25a. REC'D BY REGISTRAR <u>JUL 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Juerg</u>				



10335

10335

10335

10335

10335

10335

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

10740

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10733

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 22-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				d. STREET ADDRESS <u>Parker Ave R3</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Ottolene Wright</u>				4. DATE OF DEATH <u>July 1 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-1908</u> 87 yrs.	
9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DELMAR-MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CLARENCE TINGLE</u>		14. MOTHER'S MAIDEN NAME <u>MIKKIE BRITTINGHAM</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NC</u>	
16. SOCIAL SECURITY NO. <u>221-07-2309</u>		17. INFORMANT <u>ROY WRIGHT-SALISBURY MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>1527</u> DUE TO (b) <u>Adeno Carcinoma of Uterus with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>generalized metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> , 19 <u>66</u> , to <u>7/1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> , 19 <u>66</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above.				22a. SIGNATURE <u>William J. Omich</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7/1/66</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>7-3-66</u>		<u>MELSON</u>		<u>DELMAR-MD</u>	
24. FUNERAL DIRECTOR <u>Charles W. Marnel - Delmar, Md.</u>				25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			
DATE <u>JUL 5 1966</u>							

10333

10333

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "TO", "FROM", and "DATE" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10741					10734				
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>804 Spring Avenue</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>804 Spring Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JOHN DELPHIN WYNN</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>21</b> Year <b>1966</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 19/1908</b>		9. AGE (in years last birthday) <b>57</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>9</b> Days <b>2</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager- Liq. Petro. Ind.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John David Wynn</b>				14. MOTHER'S MAIDEN NAME <b>Delphia Ehrhardt</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>442-07-8800</b>		17. INFORMANT <b>Mrs. Ruth S. Wynn (Wife)</b> Address <b>804 Spring Ave. Salisbury, Maryland 21801</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 4201 DUE TO (b) <b>Embolism, probably from heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Obstructive Airway Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>26 hrs.</b> <b>20 hrs.</b> <b>3 yrs.</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/21</b> , 19 <b>66</b> , to <b>7/21</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/21</b> , 19 <b>66</b> , and that death occurred at <b>11:30</b> PM, from the causes and on the date stated above.									
22a. SIGNATURE <b>Rufus S. Gardner Jr.</b>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>July 23/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner Jr.</b>				22d. ADDRESS <b>Pine Bluff Road Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>July 25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JUL 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1973

1973

Washington

Washington

Washington

Delaware

Delaware

100 Spring Ave.

100 Spring Ave.

06

21

JULY

1973

JOHN

JOHN

White

White

Oct. 19/1900

Oklahoma

John David Lynn

Delaware

John David Lynn

100 Spring Ave.

402-27-2800

402-27-2800

*[Faint, illegible handwritten notes and signatures]*

*[Faint, illegible handwritten notes and signatures]*

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Then please remove carbon papers. Pages 1 and 2~~ should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

10235

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>6 mo. 28 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ernest</b>		First Middle Last <b>Younger</b>		4. DATE OF DEATH Month Day Year <b>July 17 19 66</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>July 26, 1886</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Daniel P. Younger</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth DeFord</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214 12 6055 A</b>		17. INFORMANT <b>Sudlersville, Md. Ethel Jennings</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular disease</b> (c) <b>Chronic pulmonary emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 20, 1965</b> to <b>July 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 17, 1966</b> , and that death occurred at <b>12:10 AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>L. Maldve</b>		22b. DATE SIGNED <b>7-17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Maldve, M.D.</b>		22d. ADDRESS <b>Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/20, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cem.</b>	
23d. LOCATION (City, town or county) (State) <b>near Rock Hall Chestertown, Md</b>		24. FUNERAL DIRECTOR <b>J. Wells Wells</b>		25a. REC'D BY REGISTRAR <b>JUL 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



10333

10333



U.S. DEPARTMENT OF JUSTICE

UNITED STATES DISTRICT COURT

IN RE: [Name]

Case No. [Number]

Memorandum of Decision

U.S. District Judge [Name]

U.S. District Court

U.S. District Judge

U.S. District Court

U.S. District Judge

U.S. District Court

U.S. District Judge